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MEDICAL POLICIES AND COSTS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON CONSUMER ECONOMICS

OF THE

JOINT ECONOMIC COMMITTEE

CONGRESS OF THE UNITED STATES

NINETY-THIRD CONGRESS

FIRST SESSION

MAY 15 AND 16, 1973

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MEDICAL POLICIES AND COSTS

TUESDAY, MAY 15, 1973

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON CONSUMER ECONOMICS
OF THE JOINT ECONOMIC COMMITTEE.
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:35 a.m., in room 4221, Dirksen Senate Office Building, Hon. Hubert H. Humphrey (chairman of the subcommittee) presiding.

Present: Senators Humphrey and Javits.

Also present: Jerry J. Jasinowski and L. Douglas Lee, professional staff members; Michael J. Runde, administrative assistant; and Leslie J. Bander, minority economist.

OPENING STATEMENT OF CHAIRMAN HUMPHREY

Chairman HUMPHREY. Thank you for joining us. This morning the Subcommittee on Consumer Economics of the Joint Economic Committee begins 2 days of hearings on the cost of medical care, a significant factor in the high cost of living.

People in this country should enjoy the best medical care in the world. Yet we are not meeting this potential. We have the best physicians, the best hospitals, and the best schools. But all of these resources are useless to those men, women and children who cannot get to them when in need or to those who just don't have the money to buy the medical care that is available.

Over the past 20 years, the cost of medical care—I include hospital care as well as outpatient—has soared.

In 1950, personal health care spending was $12 billion. But in fiscal 1972, the total bill was $83.4 billion.

In 1950, the protection of health consumed about 4.6 percent of the gross national product, or $78 per capita. In 1971, it consumed 7.4 percent of the GNP, or $358 per capita. During last year alone, health costs jumped by $26 per person.

We spend a larger percentage of our GNP and more money per person on health care than any other people in the world.

How healthy are we as a result of all these outlays? In 1970, the United States ranked 15th in the rate of infant mortality among industrial nations.

For those that survive, the life expectancy is generally shorter than in other developed countries. In 10 nations, the expectancy for females exceeds the 73.8 year average for the United States, for blacks and other minorities, the American life expectancy is significantly shorter.

Despite the facts, the administration's view of these problems seems

less than urgent. The former Secretary of HEW, Secretary Elliot Richardson, indicated that administration proposals would be presented near the end of last year. That deadline was later postponed with the promise that the proposals would accompany the 1974 budget.

In his confirmation hearings, the new HEW Secretary, Caspar Weinberger, indicated that they would be available sometime in February or March. February and March have come and gone and all Congress has seen is the statistical evidence of the 1974 budget.

And this 1974 health budget gives little promise of helping Americans to meet their health care needs. In fact, the impact of this budget will be to make the situation worse for many pepole.

For example, the administration would like to reduce medicare payments, thus increasing the patient's cost for an average hospital stay by about 125 percent. An average hospital say today costs the medicare covered patient $84.

I think that figure ought to be adjusted upward as I will indicate in just a minute. I think that is far too modest.

If the administration's proposals are enacted, the cost of the average hospital stay to the medicare-covered patient will be $189.

The administration wishes to:

Phase out Federal support for community mental health centers;

Terminate Federal support for hospital construction; and

Drastically cut aid to medical schools and students.

I noted yesterday in the press that a couple of medical schools here in the District of Columbia are facing closing their doors. I might add the Government is in flagrant violation of a contract of the University of Minnesota Medical School agreeing to supply funds if the school would double its enrollment, particularly for general practitioners.

The State of Minnesota put up some $13 million. The Federal Government was to match it. The Federal Government reneged, guilty of noncompliance with contract.

Under any other system those persons would be punished and held liable for violation of contract, but that has become a habit in the Government of the United States, to break your word and violate contract and break the law.

The administration wishes also to:

End Federal support for regional medical programs; and

Reduce funding for disease control programs.

This administration program, if it can be called that, seems to be withdrawal on practically all fronts. And yet the Congress has been provided with little information which would justify these changes or even show that they have received careful consideration.

I shall not comment upon the veto of the vocational services of the Rehabilitation Act which was the most unkind and cruel veto in my memory; and by the way, was absurd economics, absolute stupidity, because the rehabilitation of physically and mentally handicapped is not only a blessing to those who receive the help but is a distinct aid to the economy, but apparently it wasn't in the administration's computer and if it isn't in the administration's computer, it can't be in their heart, because they are one and the same thing.

Today we are fortunate to have several expert witnesses to discuss the cost and availability of medical care, including the effects of the

administration's program, as part of our series of inquiries into the high cost of living.

Our first witness is Dr. John Cooper, president of the Association of American Medical Colleges. Dr. Cooper had a distinguished career as a professor of biochemistry and dean of sciences at Northwestern University before coming to the AAMC. He is, therefore, in an excellent position to discuss the impact on medical schools and general research of the 1974 budget.

The next witness will be Mrs. Karen Davis, a research associate at the Brookings Institution. Mrs. Davis has been a Brookings Economic Policy Fellow at the Social Security Administration and assistant professor of economics at Rice University. She is an expert in health insurance and the causes of rising hospital costs.

Our third witness is Mr. Alfred Neal, who is president of the Committee for Economic Development. The CED is one of the very few institutions which has outlined an overall strategy for providing health care for our people. We are pleased to have Mr. Neal with us today to discuss their proposals.

I might add I was home this weekend in Minnesota, and I found the following little newspaper items that were attracting considerable attention.

Here is an item, "Costs of stay in hospital rises 7.9 percent last year," from the Minneapolis Tribune, Monday, May 7:

> The average cost of patients' stay in Minneapolis Hospital was $117.52 a day during the 12 months ending March 31, up 12 percent according to a Blue Cross release study.
>
> Hospital charges have been going up about 12 percent a year both in the Twin Cities and nationally. The current Minneapolis average is more than double the $54 average in 1965. That has been $108 a day during the 12 months ending March 1, 1972.

Then there is a full analysis of the studies of Minneapolis hospitals, St. Paul hospitals, Duluth hospitals and Minnesota averages.

St. Paul hospitals have had about the same kind of rise.

I have the Pioneer Press of the same day from St. Paul. It says, "Hospital fees up 7.7 percent, daily charge over $100."

That was an average increase of 7.7 percent since March 31, 1972, according to a 12-month study of 183 Minnesota hospitals released Sunday by Minnesota Blue Cross and Blue Shield.

I think that we have here a categorical and emphatic evidence as to what has been happening in terms of hospital costs. This has no relationship, however, to other costs that face our people, pharmaceuticals, which are high, doctors' fees, other services which are provided.

So that today part of the pattern of the economic picture is the costs in medical and hospital services.

We have had hearings on industrial crises. We have had hearings on food prices. We have had hearings on gasoline, and one of the things that is quite interesting to me and yet at the same time very disturbing and distressing, is that for some reason or another, the Government, the administration doesn't seem to realize that there is something happening in this country. The costs are really going out of the roof. They are really going up all over the country in whatever you touch. There is a kind of an ambivalent attitude here.

I noticed the other day where one of the leading spokesmen of the

administration said he hoped that by the end of the year we could phase out all price controls. Well, I don't know what they are smoking, but that sure is giving somebody a spirit of euphoria that is not related to facts unless you don't care.

Now, having enunciated a few of my concerns this morning, I would like to invite as our first witness Dr. Cooper to be here as our first witness.

STATEMENT OF JOHN A. D. COOPER, M.D., PRESIDENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. Cooper. Thank you very much, Mr. Chairman.

The Association has a rather lengthy prepared statement plus an even lengthier report on a survey that was recently completed on the impact of the amended fiscal 1973 budget submitted by the administration and the administration's proposed fiscal 1974 budget on the Nation's medical schools.

Chairman Humphrey. First of all, may I ask just what does the Association of Medical Colleges represent or what are the institutions?

Dr. Cooper. It is a 97-year-old association which now represents all of the medical schools in the United States. It represents 51 professional societies which range all the way from the American Association of Anatomists to the American College of Surgeons.

It also represents 400 of the major teaching hospitals of the country.

Chairman Humphrey. Thank you.

Dr. Cooper. It recently reorganized itself to represent this broader group of organizations and institutions connected with medical education, and has just extended voting privileges to student representatives to the association.

Chairman Humphrey. Proceed.

Dr. Cooper. The long prepared statement and the survey I would like to submit for the record and summarize briefly here, if that is agreeable.

Chairman Humphrey. Please do that. The submissions for the record will be placed at the end of your oral statement.

Dr. Cooper. We do appreciate this invitation to testify today. The membership of the association is looking forward to working with you in the months and years ahead on a matter which we know is of deep concern to you—improving the health of our people.

I doubt if anybody here would agree with the President's statement that one component of this health-care crisis is the rapidly rising costs of medical care. Biomedical research is one of the fundamental factors in determining the cost of medical care. It makes possible the control of disease through prevention or diagnosis and treatment. One of the things we have learned is that incomplete knowledge about disease is expensive.

The availability of professional health personnel also helps to determine medical costs because it determines how and by whom medical care is provided.

Support of medical education is needed to increase the numbers and to improve the distribution of physicians. It is also important to permit the appropriate use of all health professionals in the team approach to all medical care, particularly primary care. As

biomedical research and the availability of health personnel are reduce, the quality of medical care goes down and the medical costs go up.

Unfortunately, the administration's budget for fiscal 1974 seems not to recognize this relationship.

The association is especially concerned about proposed cuts in research supported through the National Institutes of Health and in assistance to the education of health professionals.

The association has conducted a survey of the Nation's medical schools to assess the impact of the proposed reductions in Federal support. The impact is very serious. The complete survey, which is over 30 pages long, is being submitted for the hearing record.

Here are some of the results of this survey.

One. Federal funds for research, teaching, and community service are 26 percent below the fiscal 1974 levels that the medical schools had expected by a reasonable extrapolation of previous support.

Two. While income from other sources will increase in 1974, the increase will not be able to offset the drop in Federal support.

Three. The reduced funding jeopardizes the continued employment of 1 out of 12 faculty members.

Four. One-third of the schools reported a strong possibility or having to cut back on the size of future classes.

Five. A majority of the schools reported that programs of curricular improvement would have to be curtailed or abandoned.

Six. Half of the schools reported that terminating regional medical programs may force them to limit or phase out their health care programs in rural or ghetto areas, their referral services in such matters as heart disease, cancer, stroke, kidney transplants, radiation, and emergency care and their programs of continuing education for practicing physicians.

Based on these and other findings of the survey, the association is recommending to the Appropriations Committees of the Congress that there be modest increases in five specific areas of the health budget:

One. Capitation-grant institutional support should be increased to the level necessary to maintain the fiscal 1972 dollar-level of support per student. This, of course, does not take into account increasing educational costs and thus makes this support in real dollars less than the schools received 2 years ago.

Two. Funds for regular research grants, which are investigator-initiated, should be raised to at least the fiscal 1972 level plus a cost-of-research increase of 12 percent.

Three. Funds for training grants and fellowship should be raised to the fiscal 1972 level plus a cost-of-training increase of 12 percent.

Four. Programs of health professions student loans and scholarships should be continued. There is some indication the administration wishes to phase out these programs. These funds should be increased to keep pace with expanded enrollments and to maintain past levels of assistance, particularly in view of the fact that the schools have made great progress in broadening the socioeconomic base of their classes and substantially increasing the number of minority students. These kinds of students draw heavily on the schools' financial aid funds.

Chairman HUMPHREY. Does this area relate to the trainee program or is that separate and distinct?

Dr. Cooper. The trainee program is specifically designed to assist young people who wish to go into careers of biomedical research and teaching to have additional educational training preparative to that.

The student loans and scholarships that I spoke of are specifically for medical students who are completing the work for the M.D. degree.

Our final recommendation is that construction grant programs should be continued at least at the fiscal 1972 level. There are many schools, the University of Minnesota among them, which have suffered under cutbacks in construction grants. They have planned the facilities necessary for their program requirments in increasing class sizes and expanding their contributions to the total health care program of the Nation; and these funds now are being withdrawn. There is an attempt to replace the grant funds with a guaranteed loan program which is available only to private schools and which the 71 public medical schools could not take advantage of.

Regarding biomedical research, regular research grants, which have helped make the United States a leader in medical science, have been slashed in the fiscal 1974 budget by more than 40 percent from the 1972 level. This is due to the administration's mistaken idea, in our view, that research can be made more efficient by introducing a greater degree of management and more targeting of efforts.

In fact, research does not function in that way. The leading edge in biomedicine is comprised of the new ideas and new researchers which can be developed and encouraged through new research grants. In addition, general research support grants enable the medical schools to balance the various research programs, provide support for young investigators as they get started and support research on a broad front of related fields. These funds are also being reduced.

The survey indicated fiscal 1974 funds for research were substantially below expectations and the effect on faculty salaries would be serious.

Overall, Federal research support would drop 16 percent from anticipated levels. Funds for new research grants are down 39 percent. Contract funds are down 7 percent. Funds for specialized centers are down 18 percent. General research support funds are down 71 percent. Faculty support for research grants and contracts is down 17 percent and from general research support funds is down 71 percent.

These cuts will have a serious impact on the research efforts of the medical schools.

With regard to the training grants and fellowships which are supported through NIH, they would be phased out in the administration's budget. To do this would reduce support for graduate education and for stipends available to students preparing themselves for careers in biomedical research and teaching.

Training grants and fellowships have been highly successful in producing career researchers and teachers. A recent study at the University of Washington indicated that 79 percent of basic science trainees have assumed full-time academic positions; an additional 17 percent have entered full-time research outside the academic health center. Thus, at a single university medical center, the NIH training programs have resulted in 96 percent of the trainees entering careers toward which the training grant program is directed.

The University of Minnesota reported that of 1,040 trainees directly supported by training grants, almost 70 percent have taken

academic positions. A recent survey of 68 medical schools revealed that of 3,267 internal medicine faculty members, 82 percent had received NIH training grant support during their academic development.

It is difficult to understand the administration's proposal that the marketplace be permitted to determine the interest of young people in preparing themselves for biomedical research and training. Those who enter these fields would have the prospect of a smaller income than they would have if they entered the practice of medicine. At an age when a practicing physician could expect to be earning an average annual income of $43,000, an M.D. who chose an academic career could expect to be earning only $24,000. The marketplace theory suggests that an economically rational person would be unwilling to incur substantial debt to pay for his graduate education, and to engage in an endeavor which would bring lower financial return when he could prepare for practice.

The survey also found significant and unexpected drops in fiscal 1974 funds for research training and resulting drops in the number of trainees, student stipends and faculty supports.

Funds for fellowships are down 27 percent. With the cut in training grants, for example, the numbers of trainees dropped 44 percent.

Chairman Humphrey. And that really affects the future; doesn't it?

Dr. Cooper. Yes, sir.

Chairman Humphrey. When you drop those trainee programs you are really building in scarcity for the future, not only in terms of care but also in terms of research and the breakthroughs that you hope to get.

Dr. Cooper. And with all of the pressures to increase our efforts against cancer, heart disease and other killer diseases, we are concerned about where the people are going to come from who will mount the research programs which have been established and for which the funding has been increased both in the administration's present budget and in the previous budgets passed by this Congress.

It is very important to point out the value of research, in pure economics: what it can do for disease and for reducing the cost of disease.

Dr. Lewis Thomas of Yale has developed a theory of halfway technology. This is a point at which our information about a disease is incomplete and where actually this incomplete knowledge increases the cost of the disease.

With poliomyelitis, for example, before we had any knowledge about it, it was a relatively cheap disease economically. The patient either died or was crippled and that was the end of it. Then we began research to sustain life with respirators and expanded our knowledge of fluid balances and so on, and the cost of the disease rose.

Additional research, which was very basic, concerned itself with how to grow viruses in monkey tissue, which permitted researchers to develop a vaccine. As a result, the cost of the disease has been reduced to almost zero.

Contrast that with our half-way knowledge, for example, in the expensive procedures associated with diabetes, kidney transplants, coronary bypasses, or neoplasms. None of these are really evidence of success in dealing with a disease. They are in fact confessions of failure.

For they are confessions of failure, of the lack of adequate understanding to prevent diseases before clinical signs and symptoms appear.

There has been no disease which we have ever been able to control short of having the kind of knowledge which we have, for example, in poliomyelitis.

I could cite for you some more estimates of the economic savings from research. Unfortunately, this viewpoint is not generally held. The result is serious for advancing knowledge through diomedical research.

If I might go on briefly here to the impact of the budget upon our educational programs. The problem that we face here is that the commitment between the Federal Government and the medical schools to increase their class size has never been fully met. Capitation funds have not been appropriated at the levels called for in the Comprehensive Health Manpower Training Act, yet the mandatory class size increase has been maintained at a full 100 percent of the requirement in the Act.

As we surveyed the schools, we found that capitation support, which was 70 percent of the authorization level in 1972, would drop to 64.5 percent in fiscal 1973 and continue at that level in fiscal 1974 if the administration's budget is adopted by the Congress.

This is in spite of increasing costs in the medical schools along with all of the other costs which you brought out earlier.

With this reduction, schools have no choice but to cut back on the number of faculty and staff. This dismantling will have very serious long-term effects not only on the quality of medical education, but also on the ability of the schools to expand further their enrollment if other funds can be found through either Federal or State sources.

Capitation grants are down 16 percent from what the schools anticipated they would get. Special project grants, which are another source of the funding for the schools to improve the curriculum, are down 34 percent. As a matter of fact, the amount asked for by the administration will not be sufficient to cover commitments made earlier under the special project grants which are continuing in fiscal year 1974. The special projects funds to permit an increase in minority enrollment are down 35 percent.

As a result, the impact is so serious that the schools' ability to expand is jeopardized and future plans to expand medical school enrollments will have to be abandoned. The University of Texas Medical School system planned in fiscal year 1974 to increase the first year classes by 300 students, but those plans have now been abandoned.

Student loans fall far short of need. The medical schools made an assessment for the amount of loans required to support the students; $37 million was necessary. The budget allocated $19.5 million. Against an entitlement for medical school scholarships of $15 million, the budget allocates $4.4 million. These levels make it very difficult for the medical schools to continue their efforts to expand minority enrollments.

We do not see how the necessary legislation can be enacted, as the administration proposes, to shift scholarship aid to an expanded national health service scholarship program in time for the September entering class, which the schools are faced with making commitments to right now.

The survey found the schools particularly discouraged over proposed changes in student assistance.

Chairman HUMPHREY. Could you just pause for a moment and explain to me the administration policy decision on shifting health

professional scholarship assistance to expanded health service scholarship program; what is this?

Dr. Cooper. In the fiscal 1974 administration budget, they said that they were phasing down the health professions scholarship program which is administered through the Bureau of Health Manpower Education of NIH and which is a part of the Comprehensive Health Manpower Training Act of 1971. In its place they would introduce legislation to expand the nationl health service scholarship program under the Emergency Health Personnel Act Amendments of 1972.

This was an act, which the association supported thoroughly, which provides an opportunity to assign those who graduate from medical schools to underserved areas.

The administration proposes to make all scholarship recipients liable for service in the National Health Service Corps, the Indian Health Service, or the Public Health Service. The authorization level of $3 million in the present National Health Service scholarship program is not sufficient to provide the scholarship assistance needed. So the administration plans to introduce legislation which will increase the authorization to $22.5 million. Here we are in the middle of May. This legislation would have to be passed by both Houses, and appropriations would have to be made for it.

We are terribly concerned about the students entering in September 1973 who need scholarships. They will be caught, because we won't have either program.

Chairman Humphrey. One is being canceled out and another is supposed to supplant that and that has not been acted upon, so you are caught between the chasm of the two decisions, the students are caught and there is very little chance you would have those funds by September?

Dr. Cooper. We don't see how.

The schools that we surveyed said they will not be able to maintain the increasing number of minority students that they have admitted. They simply do not have the funds to support these students, who generally come from low-income families and who require about twice the financial support that other students require. The schools are very concerned that we may be forced to admit only those students who can pay their way and thus return medicine to a profession of those who come from affluent families.

Finally, the absence of construction grant funds means that Federal construction assistance is unavailable to the 71 public medical schools, because the loan guarantee-interest subsidy program is available only to private schools.

The number of first-year places to be added under projects supported by the budget is pitifully small when compared to the number of medical school applicants who are turned down each year because the schools are unable to expand their facilities in order to accommodate increased enrollments.

The schools are being required to increase their enrollment in order to qualify for capitation-grant institutional support. Yet at the same time, they are being denied the funds they need to erect the facilities for larger enrollment.

There appears to be just as much need now for construction grants for health professions teaching facilities as there was when the program was approved in the Comprehensive Health Manpower Training

Act of 1971. The fiscal 1974 authorization is $275 million. About $350 million is approved but unfunded construction grant applications remained after the award of fiscal 1972 construction grants. In addition, the association estimates that $150 million a year is required just to maintain the existing physical facilities of the medical schools.

The survey found medical schools facing a serious dilemma, not of their own making. They are being required to increase their enrollments in order to qualify for capitation grant and yet at the same time they are being denied the funds they need to erect the facilities for the larger enrollment.

I think, sir, this would conclude the oral statement. At the appropriate time, I would be happy to answer any additional questions.

Chairman Humphrey. We will incorporate in the record the entire body of your prepared statement as prepared for the subcommittee at this point.

[The prepared statement of Dr. Cooper follows:]

Prepared Statement of John A. D. Cooper, M.D.

Costs of Medical Care and the Role of the Federal Government

Mr. Chairman and members of the subcommittees, the Association of American Medical Colleges appreciates this opportunity to appear before the subcommittee as it begins hearings on the costs of medical care generally, and on the impact of the fiscal 1974 budget proposals on future medical costs and medical care. We are grateful that the Subcommittee on Consumer Economics has concerned itself with these crucial problems. We hope that the Association can work with you and the subcommittee during the months and years ahead.

The Association, now in its 97th year, represents the whole complex of persons and institutions charged with the undergraduate and graduate education of physicians. It serves as a national spokesman for all of the 114 operational U.S. medical schools and their students, 400 of the major teaching hospitals, and 51 learned academic societies whose members are engaged in medical education and research. The Association and its membership thus have a deep and direct involvement in the matters of immediate concern to the subcommittee.

In his February, 1971, message to the Congress on health care, President Nixon said, as he had said 19 months previously, that America's medical system faced a "massive crisis." "That crisis has deepened," the President said. "All of us must now join together in a common effort to meet this crisis—each dong his own part to mobilize more effectively the enormous potential of our health care system." One component of this crisis is the rapidly rising cost of medical care.

A great many factors contribute to the costs of medical care. The subcommittee undoubtedly will consider them all during the course of these hearings. The Association will discuss two fundamental factors that are essential determinants not ony of medical costs but also of the quality of medical care. The first is the advance of biomedical research; the second is the availability of professional health personnel, and their efficient and effective utilization in the promotion of health and the prevention, diagnosis and treatment of disease.

Biomedical research is the foundation of modern health care. Through advances in knowledge we can develop the understanding of the living process and its modification by illness required to permit control of disease through prevention or diagnosis and treatment in its earliest, least harmful and least expensive phases. We really have never been able to control a disease unless we could intervene before clinical signs and symptoms appear.

A point needs to be made here about medical research and medical costs. Our incomplete knowledge about many diseases is expensive. For most diseases we are at what Dr. Lewis Thomas of the Yale University School of Medicine calls the state of half-way technology: for chronic kidney disease we have the expensive procedures of dialysis or kidney transplantation; for chronic heart disease we have open heart surgery and coronary by-passes; for neoplasms we have toxic antimetabolities, radiation or surgery. But none of these is really evidence of success in dealing with disease. They are in fact confessions of failure, of a

lack of adequate understanding to prevent disease before clinical signs and symptoms appear. They are the consequences of partial understanding.

Not many years ago we were at the point of half-way technology for poliomyelitis. The iron lung and other life saving approaches, and orthopedic procedures which gave more mobility to the paralyzed, were little more than expensive methods to ease the suffering. But further biomedical research made it possible to identify and isolate the polio virus and to grow it in monkey tissue. From this capability came a vaccine which eliminated the disease and reduced the cost of polio almost to zero. Thus the additional research carried us beyond the expensive phase of incomplete knowledge to the point of complete control of the disease by preventing its occurrence.

The second fundamental factor, the availability of professional health personnel, helps to determine medical costs because it determines how and by whom medical care is provided. Some of these professionals conduct biomedical research. Others provide the benefits of research by treating patients and operating medical equipment and facilities. Still others serve as teachers for the young physicians of the future. All of them are involved, ultimately, in providing health care to the consumers.

Medical schools need federal support not only to increase the numbers and improve the distribution of physicians, but also to provide the appropriate use of health professionals in a team approach to the delivery of primary care. Since physicians ultimately will find themselves as heads of health care teams that include specially trained nurses, physician assistants and allied health professionals, medical students are working with trainees in these professions as part of their education.

Such teams can serve as models for the delivery of primary health care in the community. Teams also are becoming a common method of prividing more highly specialized secondary and tertiary care in the teaching setting. For example, nurse midwives are now working under obstetricians to deliver babies at some academic medical centers. Teams of health professionals have long been responsible for critically ill patients in the intensive care units of most teaching hospitals.

As biomedical research and the availability of health personnel are reduced, the quality of medical care goes down—and medical costs go up. Without the discoveries and products of medical research, medical care itself becomes less efficient and more expensive. Without sufficient numbers and proper distribution of physicians and other health professionals, medical care becomes less available and more expensive.

Increasingly the federal government, and especially the Congress, have come to recognize the relationship between biomedical research and health manpower, on the one hand, and the quality and cost of medical care, on the other. But the proposed budget for fiscal 1974 evidently does not recognize that relationship.

ASSOCIATION SURVEY

When the budget was submitted early this year it was clear at once that health programs were not to receive the support they need. Of particular concern to the Association, and to the subcommittee, the requests were cut for research conducted through the National Institutes of Health and for health manpower programs. Reductions in regular research grants and in training grants and fellowships were especially severe.

The Association staff prepared a 51-page analysis of the health budget proposals and sent it, along with a 46-page questionnaire, to the nation's medical schools. Our effort was to gauge, as accurately as possible, the impact of the proposed budget on medical education. This includes the biomedical research conducted at academic health centers and the training of physicians to provide medical care.

Seventy-eight medical schools responded to the survey and made available to the Association their best judgment of the probable immediate efforts—and longer term implications—of these budget recommendations on their education, service and research functions. For the academic year 1972–73, these 78 schools enrolled seven out of every ten medical students, and accounted for about 80 percent of all medical school operating expenditures is fiscal year 1972.

With the Chairman's permission, the Association is submitting a copy of the complete survey to be included in the hearing record. The subcommittee is urged

to study this survey carefully for the information it reveals, indirectly, about the future costs of medical care.

The medical schools were asked to review their expenditures of federal funds in fiscal 1972 and their expectations of funds in fiscal 1974. Following are the principal findings of the Association's survey:

1. Federal funds available in fiscal 1974 for support of programs of research, teaching and service will drop 11 percent from the fiscal 1972 level, more than 15 percent from the level in the current fiscal year, and 26 percent from the level planned by the schools in fiscal 1974, prior to the release of the budget recommendations.

2. Income to the schools from other sources is expected to increase in fiscal 1974. But this increase will not offset the anticipated decrease in federal funds. A number of schools reported either that state legislatures would not grant requests for higher state appropriations or would not be in session even to consider such requests. Private schools have no source of income to replace lost federal funds.

3. The proposed reduced levels of fiscal 1974 federal support would require the schools to terminate the employment of one out of every 12 faculty members, unless other sources of salary support can be found. Additional income for the next academic year would be difficult to obtain at this late date.

4. In terms of undergraduate medical education, one third of the schools reporting indicated the strong possibility of having to reduce the size of future entering classes. For a considerable number of schools, future increases in first-year enrollments will not be possible. And for a majority of the reporting schools, programs for curriculum innovation may have to be abandoned or curtailed.

5. Regional Medical Programs termination—as proposed in the budget—may force about one out of two medical schools to phase out or to curtail their health care programs in rural or neighborhood ghetto areas; their referral services in such significant areas as cancer, heart disease, stroke, kidney transplants, radiation and emergency care: and their formal programs for instruction, lectures and seminars for the continuing education of practicing physicians.

ASSOCIATION RECOMMENDATIONS

Based on these and other findings of the survey, the Association has identified five general budgetary needs of the highest priority for medical education. These needs are being described in detail to the Appropriations Committees of the Senate and the House of Representatives. This subcommittee today is not concerned primarily with appropriations requests, but the Association's recommendations must be cited here because they represent the medical schools' response to the Administration's fiscal 1974 budget. The general recommendations follow, in descending order of importance.

Capitation grants.—Appropriate $168 million for capitation-grant institutional support for schools of medicine, osteopathy and dentistry, the level necessary to maintain the fiscal 1972 dollar level of support per student.

Regular research grants.—Add $79.5 million to the NIH budget for research institutes and divisions and direct that the funds are to be used to raise regular research grants for each Institute to at least the fiscal 1972 level plus a cost-of-research increase of 12 percent.

Training grants and fellowships.—Direct the continuation of the NIH research training grants and fellowships and the support of new trainees and fellows and add $82.4 million to the NIH research budget to maintain these activities at the fiscal 1972 level plus a cost-of-training increase of 12 percent. Of the $82.4-million increase, $61 million is to be allocated for training grants and $21.4 million is to be allocated for fellowships.

Student assistance.—Appropriate $46 million for health professions student loans and $19.2 million for health professions scholarships, the levels necessary to keep pace with enrollment increases or to maintain past levels of assistance. Direct that these programs are to be continued.

Construction grants.—Appropriate $140 million for construction grants for health professions teaching facilities, the same level appropriated in fiscal 1972.

From these general findings and recommendations, the Association would return the subcommittee's attention to the two fundamental factors that determine medical costs and medical care, the advance of biomedical research and the availability of professional health personnel.

Two of the Association's priority concerns—regular research grants and training grants and fellowships—are part of the NIH research budget. But the budget for fiscal 1974 shows the effect of plans to phase out these programs. This deeply concerns the Association, because these programs profoundly affect both the conduct of research and the training of research scientists and medical school faculty members.

Regular research grants

Questions are being raised by the Administration about the wisdom of maintaining federal support of our research efforts, particularly in the form that has made the United States so preeminent in medical science. The mistaken idea is held by those with backgrounds in law or economics, and who have power in decision-making in the federal establishment, that research can be made more effective and efficient by introducing a greater degree of management and more targeting of efforts.

This managerial philosophy is in direct conflict with the findings of a study conducted by the Federal Reserve Bank of Philadelphia. This study of innovations and breakthroughs in five broad areas of technological research showed that virtually all major developments resulted from small entrepreneurial research groups or individuals working outside the framework of large directed programs. As Dr. Irving Langmuir, Nobel laureate in chemistry, once observed, "Only a small part of scientific progress has resulted from a planned search for specific objectives."

Yet, federal decision-makers persist in their belief that the increased management and direction of federal research expenditures by Washington bureaucrats will lead to more immediate payoffs. This thinking is embodied in the President's budget request for NIH, where funds for regular investigator-initiated research are being reduced and money for directed research-by-contract is being increased. New and competing research grants—that is, funds for new investigator-initiated projects—have been slashed by more than 40 percent from the 1972 level. Furthermore, the increased federal support for heart and cancer research, proposed in the fiscal 1974 budget, draws funds away from research in other fields. This can thwart the synergistic benefits of a balanced, coordinated national program of research into the physical and mental diseases and impairments of man.

The thrust of biomedical research is to find the scientific basis for the subsequent development of improved methods for the treatment of disease. The leading edge in biomedicine is comprised of the new ideas and the new researchers which can be developed and encouraged through new research grants. The value of funds directed to the support of specific research projects is, in turn, multiplied by funds providing general research support. These can be used at the discretion of an institution in the development of new research programs, providing initial support for young investigators, undertaking pilot projects and feasibility studies, and supporting centralized facilities and services needed by multiple investigators. General research support funds enable an institution to balance its various research programs and to support research along a broad front of related fields.

While most efforts at measuring the economic benefits of biomedical research suffer from the difficulty of measuring the vast array of imponderables that must be included in any assessment, it is possible in some specific disease areas to produce meaningful information. The use of polio vaccine, for example, resulted in savings in medical care costs along of more than $326.8 million between 1955 and 1961, according to a study prepared by James W. Colbert, Jr., M.D., vice president for academic affairs of the Medical University of South Carolina, for an American Biology Council task force on the contributions of biology to human welfare. Similarly, he estimated that the benefit from 1963 to 1968 due to immunization against measles amounted to more than $531.5 million. Other studies have reported on savings in other fields. Improved treatment of tuberculosis produced savings of $5 billion in the period 1954 to 1969. Still other illustrations of the value of basic research include: L-Dopa for Parkinson's disease, an annual savings of $1.2 billion; prophylaxis of carcinoma of the cervix by the Papanicolaou smear, an annual saving of $1.1 billion.

Survey results.—Responding to the Association's survey, the medical schools indicated that fiscal 1974 federal funds for research were substantially below expectations and that the effect on faculty salaries supported from federal re-

search funds would be serious. This drop in federal research funds is to come at the same time the schools expect nonfederal research support to remain virtually unchanged. Overall, the schools reported, federal research support would drop 16 percent from anticipated levels. Funds for new research grants are down 39 percent; contract funds are down 7 percent; funds for specialized centers are down 18 percent; general research support funds are down 71 percent. Faculty support from research grants and contracts is down 17 percent, and from general research suppot funds is down 71 percent.

Training grants and fellowships

In addition to these reductions in regular research grants, the fiscal 1974 budget proposes phasing out the research retaining and fellowship programs supported through NIH.

To phase out training grant programs would reduce support for graduate education and for stipends available to students preparing themselves for careers in biomedical research and teaching. Institutional support under training grants has made it possible for the medical schools to develop formal educational programs to prepare students with advanced knowledge in their field of interest and related disciplinary fields. After the students have had this initial preparation, their support usually has been transferred to research project grants during the period in which they actually have been obtaining research training at the laboratory bench under the tutelage of their faculty perceptor.

Training grants and fellowships have been highly successful in producing career researchers and teachers. A recent study at the University of Washington indicated that 79 percent of basic science trainees have assumed full-time academic positions; an additional 17 percent have entered full-time research outside the academic health center. Thus, at a single university medical center, the NIH training programs have resulted in 96 percent of the trainees entering careers toward which the training grant program is directed. The University of Minnesota reported that of 1,040 trainees directly supported by training grants, almost 70 percent have taken academic positions. A recent survey of 68 medical schools revealed that of 3,267 internal medicine faculty members, 82 percent had received NIH training grant support during their academic development.

Despite this evidence, the lawyers and economists in the federal hierarchy believe that support of research training is an inappropriate government activity. They cite the "excess of qualified scientific manpower," concluding that an oversupply exists simply because there are not enough federal research dollars to support all the approved projects. They maintain that research must compete in the marketplace with other career opportunities, surviving only on the basis of its attractiveness as a profession. In rejecting the federal role of promoting careers in the public interest, this Administration has apparently endorsed Adam Smith's 18th Century notion that "an invisible hand" will guide the free marketplace toward achieving the common good.

It is difficult to understand the proposal that the marketplace be permitted to determine the interest of young people in preparing themselves for biomedical research and training. Those who enter these fields would have the prospect of a smaller income than they would have if they entered the practice of medicine. At an age when a practicing physician could expect to be earning and average annual income of $43,000, an M.D. who chose an academic career could expect to be earning only $24,000. The marketplace theory suggests that an economically rational person would be unwilling to incur substantial debt to pay for his graduate education, and to engage in an endeavor which would bring lower financial return when he could prepare for practice in programs that would provide income during the training period and would result in a greater stream of earnings once the training was completed.

Survey results.—Responding to the Association's survey, the schools reported significant unexpected drops in fiscal 1974 funds for research training and resulting drops in numbers of trainees, student stipends, and faculty support. Funds for training grants are down 42 percent; funds for fellowships are down 27 percent. As a result, numbers of trainees or fellows, student stipends and faculty support are down comparable amounts. Because of the cut in training grants, for example, the number of trainees is to drop 44 percent, stipends are to drop 39 percent, and faculty support is to drop 45 percent.

EDUCATION OF HEALTH PROFESSIONALS

Three of the Association's priority concerns—capitation grants, student assistance and construction grants—are part of the NIH health manpower budget for medical, dental and related health professions. The fiscal 1974 request of $271,206,000 is $14.1 million below the amended fiscal 1973 budget and $173.6 million below the level of fiscal 1972 appropriations. These reductions are a direct result of lower per-student capitation support, of plans to shift health professions scholarship assistance to the national health service scholarship program of the Health Services and Mental Health Administration, and of a decision to terminate grant assistance for the construction of health professions teaching facilities.

Institutional support

Aside from special start-up assistance for new schools or for schools of basic science converting to degree-granting medical schools, institutional support is comprised of capitation grants, special project grants and financial distress grants. Capitation grants are by far the most important type of assistance, accounting for 75 percent of the fiscal 1974 request for institutional support. The Comprehensive Health Manpower Training Act of 1971 required the schools to meet certain enrollment increases in order to qualify for capitation grants. Actual capitation grant support never has met the authorized levels of such support (and in fact drops from the 1972 level of 70 percent to a proposed 1974 level of 64.9 percent), but the schools have been required to meet a full 100 percent of the legislatively mandated enrollment increases.

Faced with an immediate need for sizable budget savings, medical schools have virtually no choice but to cut back on the number of faculty and staff. Medical education is highly labor intensive. Salaries and fringe benefits account for some 60–70 percent of the operating budgets of the schools, compared to 30 percent of the operating budgets for industry. The medical schools already anticipate having to terminate or to find other means of support for about one out of 12 faculty members as a result of indicated fiscal 1974 budget reductions. As grave as such reductions are in their effect on medical education programs in the coming year, the implications for future years are even more serious. This is so because a talented and imaginative faculty, once disassembled, is not easily reassembled. Thus, dismantling a school's faculty in order to save money in fiscal 1974, affects not only the short-term prospects for progress in health but also the long-term prospects.

Survey results.—Responding to the Association's survey, the schools reported unexpected fiscal 1974 drops in each of the major programs of institutional support. Fiscal 1974 capitation grant funds are down 16 percent from anticipated levels. Special project support is down 34 percent for physician augmentation projects, down 36 percent for curriculum improvement projects, and down 35 percent for minority enrollment projects. Financial distress assistance is down 69 percent. As a result of this unexpected loss in federal institutional support, the schools reported plans to reduce enrollment, to reduce faculty and staff (or leave vacancies unfilled), and to abandon proposed curriculum inmprovement projects.

Student assistance

Funds for health professions student loans fall far short of the need, Against requests from the medical schools for $37 million in loans, the budget allocates $19.5 million. Against an entitlement by formula of $15 million for medical student scholarships, the budget allocates $4.4 million. This reflects an Administration policy decision to shift health professions scholarship assistance to an expanded national health service scholarship program. The Association does not see how the necessary legislation can be enacted and implemented in time for the September, 1973, entering class.

The immediate lack of adequate scholarship and loan funds to support students from lower socioeconomic levels makes it difficult for the medical schools to continue their efforts to expand minority enrollments and to broaden the socioeconomic background of the student body. In the current academic year, it is estimated that 27 percent of medical students received health professions loans and that 15 percent received health professions scholarships.

The Health Profession Scholarship Program plays an essential role in support of low income medical students. In a separate survey of financial aid needs recently conducted by the Association, it was found that about 20 percent of the

current total enrollment of medical students are from families whose gross parental income is less than $10,000 a year. Based on incomplete returns, the Association found that low income students represent 50 percent of the scholarship recipients and 61 percent of all scholarship dollars awarded. Of significance is the fact that the Health Professions Scholarship awards represent approximately one-third of all scholarship funds and thus are a critical component of support for these students.

Although may low income students do secure loans to help them meet medical school expenses, they are understandably reluctant to overburden themselves with financial obligations. In order to attract low income students to a career in medicine it is absolutely necessary that medical schools be in a position to balance scholarship and loan support for such students and to keep the commitments they make. This is the reason that a strong health Professions Scholarship Program is essential and should be maintained at adequate levels.

Survey results.—The schools were particularly discouraged at the proposed changes in health professions student assistance. Economically disadvantaged students account for a disproportionately large share of scholarship assistance, and the proposed drop in health professions scholarship will force the schools to abandon plans to enroll more disadvantaged students. More than half the schools reporting, for example, said they would be unable to increase the enrollment of low-income students in the face of reduced scholarship aid. Nearly a third of the reporting schools were concerned that new entering classes would be composed almost exclusively of students from affluent families.

Construction assistance

The fiscal 1974 budget requests no construction grants for health professions teaching facilities. Instead, its only request for construction assistance is $1 million for federal interest subsidies on federally guaranteed loans. These funds are to be used to make payments on at least six previously approved projects which will add approximately 80 first-year places upon completion.

A number of problems arise with such an approach. (1) The loan guarantee-interest subsidy program is available only for private schools, thus effectively blocking the 71 public medical schools from federal construction assistance, and forcing them to rely upon debt financing if it is available. (2) The number of first-year places to be added under projects supported by the budget is pitifully small when compared to the number of medical school applicants who are turned down each year because the schools are unable to expand their facilities in order to accommodate increased enrollments. (3) The schools are being required to increase their enrollment in order to qualify for capitation-grant institutional

support. Yet at the same time, they are being denied the funds they need to erect the facilities for larger enrollment.

There appears to be just as much need now for construction grants for health professions teaching facilities as there was when the program was approved in the Comprehensive Health Manpower Training Act of 1971. The fiscal 1974 authorization is $275 million. About $350 million in approved but unfunded construction grant applications remained after the award of fiscal 1972 construction grants. In addition, the Association estimates that $150 million a year is required just to maintain the existing physical facilities of the medical schools.

Survey results.—One example from the Association's survey illustrates one of the construction dilemmas facing medical schools. A school reported: "The expansion of enrollment and faculty at this school has proceeded far more rapidly than the expansion of the physical plan, and the faculty is now housed in cramped quarters, including 25 trailers, three 'temporary' buildings, and 78,400 square feet of rented space. Planning funds for an additional building have been approved by the state legislature; but with the loss of federal grants, there is a serious question of whether the state can provide 100 percent funding for the needed construction. Since this is a state institution, the program of guaranteed loans and interest subsidy will not solve our construction needs."

The Association hopes the subcommittee understands the serious implications of the fiscal 1974 budget on biomedical research and the education of health professionals in the immediate future, and on medical care and medical costs in the years to come. Again, the Association urges a careful study of the medical schools' survey included as part of this testimony. It is the most complete statement of its kind now available, and its significance for the eventual consumer interests in medical care should not be underestimated.

Chairman HUMPHREY. Do you have some other data that you wished to have included in the record?

Dr. COOPER. Yes.

Chairman HUMPHREY. How would that be identified?

Dr. COOPER. This will be identified as the results of a survey by the association of the implications of the President's fiscal year 1974 budget recommendations on programs of the Nation's medical schools.

Chairman HUMPHREY. We thank you very much.

We will include that in the record at this point.

[The survey referred to above follows:]

ASSOCIATION OF
AMERICAN MEDICAL COLLEGES

NATION'S RESOURCES FOR MEDICAL EDUCATION---

IMPLICATIONS OF THE PRESIDENT'S FISCAL YEAR 1974 BUDGET RECOMMENDATIONS ON PROGRAMS OF THE NATION'S MEDICAL SCHOOLS

April 1973

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Estimates of the impact of the proposed Federal budget as reported by seventy-eight medical schools in terms of the research and graduate education programs administered by the major components of the National Institutes of Health, the National Institute of Mental Health, other components of the Health Services and Mental Health Administration, and all other Federal agencies.

NATION'S RESOURCES FOR MEDICAL EDUCATION

IMPLICATIONS OF THE PRESIDENT'S FY 1974 BUDGET
RECOMMENDATIONS ON PROGRAMS OF THE NATION'S MEDICAL SCHOOLS

Seventy-eight of the nation's medical schools have reviewed the proposed fiscal 1974 federal budget and have made available to the Association of American Medical Colleges their best judgment of the probable immediate effect --- and longer term implications --- of these budget recommendations on their education, service, and research functions. For the academic year 1972-73, the seventy-eight schools enrolled seven out of every ten medical students, and accounted for about 80 percent of all medical school operating expenditures in fiscal year 1972.

The medical schools developed a set of quantitative data and narrative descriptions. These show, in the perspective of their fiscal 1972 actual expenditures and fiscal 1973 estimates, the levels of federally supported activities anticipated for the coming year, in the light of the proposed Federal budget. The schools have also provided information on the activity levels planned for fiscal 1974 prior to the release last January of the Administration's recommendations.

SUMMARY

The implications of the proposed Federal budget, as reported by the medical schools, may be summarized as follows:

. . . Prior Federal commitments for support of programs undertaken in good faith by medical schools to respond to National goals sharply reduced or in some areas completely eliminated.

. . . Federal support reduced 15 percent from current fiscal year 1973 levels, and 25 percent from levels planned prior to January 29. Funds from other sources will be greater in 1974, but the additional non-federal income was anticipated in the plans for next year's activities. The proposed reduced Federal support affects all medical school functions; adjustments are therefore not possible within and among programs to minimize the effect of the reduced support. The fiscal 1974 deficit would be even larger were carry-over funds not available; the implications for future years will be more serious because carry-overs will not be available.

. . . Faculty loss of approximately one out of twelve, at a minimum. Faculty whose salaries are paid from Federal funds are involved in all medical school functions. The reduction in staff is inconsistent with the National objective to increase student enrollment and improve health care. To provide students with current scientific knowledge requires an instructional staff involved in research. The increased teaching duties for a reduced staff, however, may prevent this, affecting the educator's scientific competence. Moreover, the loss of research opportunity decreases the appeal of an academic career; retention of the best faculty is thereby endangered.

. . . Curricula innovations planned or underway abandoned or curtailed. Reduced Federal assistance will impede efforts to provide medical education that is more relevant to current health needs --- primary care, team practice, earlier involvement of the medical student in clinical settings, interaction with other health professions --- and the use of instructional aids and improved educational techonology.

. . . An increased medical student enrollment, and a student body that is more representative of the ethnic and income stratifications of the population, not realized as fully as National objectives dictate. The size of the entering medical school class may have to be reduced, in some instances, from the planned levels because of inadequate funding of per capita allowances. Students from minority and disadvantaged segments of the population will find reduced availability of scholarship funds a serious deterrent; these students do not view loans as an alternative. Instructional programs necessary to assist minority and disadvantaged students to make up deficiencies in undergraduate preparation will be curtailed. The educational programs for all students will be affected by reductions in faculty and in the programs to provide a more relevant educational experience.

. . . Federal support for new research investigations in all areas of biomedical sciences sharply reduced. The number of new research ideas supported will be cut by 40 percent from current levels. This loss in momentum and thrust of scientific inquiry may not become immediately apparent, but the slowing of the process to find new knowledge will ultimately affect the probability of success in targeted research. Medical school resources for research provide the unique combination of highly qualified scientists for fundamental and applied investigations, the opportunity for clinical testing of the findings, and the setting for imparting the spirit of inquiry and understanding to all students --- the great majority will become practicing physicians, fewer will find careers in academic medicine.

. . . The elimination of the regional medical programs seriously curtails medical school resources to become more involved in neighborhood community health programs and to provide assistance to ghetto and rural areas. Referral and communication services to the practicing physician, which have served as the means for making advances in treatment more widely available, may have to be abandoned.

. . . Federal support essential for construction of new and replacement of outmoded educational facilities eliminated. Guaranteed loans are self-defeating; educational facilities are not revenue producing, and many state legislatures prohibit borrowing by public institutions. This situation is particularly acute for new and developing institutions, some of whom had received support for initial phases of their construction program.

Narrative Statements

The following evaluation of the proposed reductions in Federal appropriations emerges from the narrative statements provided by the medical schools.

An Overview

. . . Medical schools are a national health resource. Activities initiated and sponsored with Federal assistance provide for the education of physicians and other health professionals to meet the evolving and growing demands for health care, to provide the faculty for the education of the next generation of physicians, and to seek new knowledge--in all areas of biomedical science--which alone can reduce the burden of morbidity and prolong life. Federal assistance at adequate and sustained levels for these activities is essential if the academic medical centers are to continue as productive institutions. The success of these programs remains to be tested by time. But it is a gamble to contend that the nation's need for fully trained health professionals can be adequately met if these programs are phased out or reduced.

. . . There is a great concern that the high degree of interrelationship of the functions of a medical school may not have been fully considered in the formulation of the proposed fiscal 1974 budget. Reduced funding levels for what may appear to be specific and unrelated Federal programs will also have a cumulative effect on the resource capabilities of the school to accomplish objectives in areas other than those targeted for reduced support. To illustrate: proposed phasing out of support for research training will have specific results relating directly to that activity. But should these cuts occur, there will also be an effect on the medical school resources to maintain departmental instructional strengths to assure the attainment of objectives in undergraduate medical education, an objective supposedly not considered to be affected by the targeted program reduction in research training.

. . . Medical schools have not had the necessary time to successfully plan an accommodation to the proposed pervasive Federal budgetary reductions. Since the combined proposals affect all functions of the medical school, adjustments within and among programs cannot be decided rationally with priorities established to minimize the damaging effect of the proposed reductions in support levels. The need for adequate lead

time is urgent, particularly where faculty appointments and the employment of other staff must be terminated. Employment arrangements, particularly for tenured faculty, and other staff require advance notice, in many instances of at least one year.

. . . One out of two medical schools indicated no alternative source of funds to replace the Federal support should the proposed reductions occur; six schools indicated that increased state appropriations would not be approved by state legislatures; in some states the legislatures will not be in session to consider the requests; revenue sharing funds will be sought, but how these funds will be allocated is unknown.

. . . As grave as these proposed reductions are in their effect on programs for the coming year, implications for successive years are more serious. Dismantlement of faculty and loss of other resources affects not only the short-term prospect for progress in health. The prospect for achieving longer-term goals is also dimmed, since these resource losses are not easily reversible.

Undergraduate Medical Education

. . . Medical schools have programmed an intensive expansion in undergraduate medical student enrollment, in line with the President's expressed desire to respond, "to the challenge of expanding health manpower." 1] This partnership in effort between the government and the medical schools has brought about the expansion of medical student enrollment from the 35,000 level of 1969 to the 44,000 total in 1972, and an estimated 50,000 medical students expected in the academic year corresponding to fiscal 1974. Along with this thrust to increase the number of students, medical schools were also encouraged to utilize their resources to: improve curricula; develop programs to shorten the period of training; encourage the enrollment of students from minority and low-income groups, and expand special training programs in such areas as family medicine, alcoholism, and drug dependence.

But the medical schools are concerned that the proposed reduced levels of funding for these special projects and the inadequate funding of support based on the numbers of students will not provide the resources to continue these activities at their planned levels, or to initiate additional programs to accomplish these national objectives. One-third of the

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1] Statement of President Nixon, November 18, 1971, on the occasion of signing into law, the Comprehensive Health Manpower Training Act of 1971.

schools have indicated the strong possibility of having to reduce the size of future entering classes; for a considerable number of schools, future increases in first-year enrollment will not be possible; and for a majority of the schools, programs for curricula improvement may have to be abandoned or curtailed.

Minority and Disadvantaged Students

. . . Increased opportunities for careers in medicine of students from minority and low-income segments of the population are endangered by the proposed reductions in scholarships, loans, and special project funds. 1] Disadvantaged students are usually reluctant to seek loan assistance, and scholarships are particularly crucial for this group. Thirty-six of the medical schools report that it will not be possible to increase enrollment of these students without increased Federal assistance. Programs to provide necessary remedial instruction so that these students can successfully pursue the medical program may have to be curtailed or abandoned in more than ten of the schools now providing such assistance. Almost one out of three schools are concerned that efforts to broaden the composition of the medical student body will be unsuccessful, and that new entering classes will be composed almost exclusively of students from affluent families.

Graduate Education

. . . The medical school's capability to provide graduate education programs that reflect current scientific knowledge is dependent upon faculty and departmental resources that span the germane scientific specialties and sub-specialties. These resources have been developed in large measure through Federal assistance. The quality of undergraduate medical education is also dependent upon the strengths of these same departments. The proposed phase out of Federally supported graduate research training programs will have a devastating effect upon the basic and clinical science departments and their effectiveness to maintain scientific competence. The budget recommendation on the research training program affects not only the future supply of persons trained for careers in academic medicine and research, but it also threatens the scientific soundness of the education program for the new physician.

1] Based on preliminary results of an AAMC questionnaire sent to medical school Financial Aid Officers on April 2, 1973.

Biomedical Research

. . . The proposed sharply reduced levels of support for new investigations in all scientific areas (including those germane to cancer and cardiovascular research) is ominous. The thrust of investigator-initiated research, peer reviewed for scientific merit and competence, is to find the scientific basis for the subsequent development of improved methods for the treatment of disease. The momentum gained over the past decade by this wide-ranging effort along all scientific frontiers may be irretrievably lost. The research supported through increased contractual arrangements, primarily in the cancer and heart areas, have specific targeted objectives, building upon existing knowledge. These contractual activities are not designed to provide new dimensions to the scientific base. Effective future targeted research may be seriously impeded, should the levels of support be reduced for current fundamental investigations in the biomedical sciences. This situation is further exacerbated by the decision to reduce institutional funds provided through general research support grants.

Community Health Services

. . . Medical schools and their affiliated teaching hospitals constitute a major health care resource. These institutions have become even more responsive to the health needs of the communities in which they are located through their association with the regional medical consortia. The proposed elimination of Federal support for this activity may force some medical schools--about one out of two--to phase out or curtail their health care programs in rural or neighboring ghetto areas, their referral services in such significant areas as cancer, heart disease, stroke, renal transplants, radiation, and emergency care, and their formal programs for instruction, lectures, and seminars for the continuing education of the practicing physician.

Faculty and Other Staff Resources

. . . The loss of faculty and supporting staff is the clearest evidence of the effect on medical center programs of the proposed reduced levels of Federal involvement in health. A few of the medical centers indicate that they will be able to avoid terminating faculty and other staff, but the vast majority of the responding institutions will not.

The effect of the proposed budgetary reduction on faculty in the coming fiscal year is estimated to require medical schools to terminate or find other means of salary support

for one out of six faculty members (full-time equivalents) whose activities in education, research, and service were paid for from Federal funds in the current fiscal 1973 year. This represents a probable minimum loss of one out of twelve faculty members when account is taken of the faculty members who do not receive salary support from Federal grants and contracts. This latter group is estimated to number 50 percent of the total faculty in medical schools. A comparable reduction may be necessary in the supporting staff.

This loss of faculty and other staff is projected to occur in the very period when student enrollment is increasing, and when there is an urgent need for greater participation of the schools in community health services. Moreover, there will probably be a disproportionate loss of junior faculty, who are entering their most productive years, and who are likely to be the most stimulating and innovative contacts for the medical student.

The Quantitative Data

A comprehensive analysis of the President's Fiscal Year 1974 Budget recommendations for health programs was prepared by the Association of American Medical Colleges. Using this analysis, medical schools reported their best judgment of expenditures of Federal funds for the support of programs in education, research, and health services. Two levels of estimates for the current fiscal year and for fiscal year 1974 were reported:

(1) Expenditures planned by the school prior to the release of the President's budget;

(2) Expenditures reflecting the reduced levels of Federal support as recommended in the President's budget.

Medical schools were also requested to provide their actual expenditures for fiscal year 1972, so that a firm basis of expenditures for the last complete fiscal year would be available.

An Overview

From their evaluation of the impact of the proposed fiscal 1974 budget, the seventy-eight medical schools report that:

. . . Fiscal year 1974 expenditures of funds provided by the Federal Government 1] for the support of programs in education, research, and health services will

- Decline 11 percent from the actual fiscal 1972 level of $755 million (Table 1)
- Decline more than 15 percent from the estimated totals for the current fiscal year, and
- Decline 26 percent from the level planned by the medical schools for fiscal year 1974 prior to the release of the budget recommendations.

. . . Medical school income from all other sources is estimated to increase in fiscal year 1974. But this increase was anticipated prior to the release of the President's budget recommendations. There is, therefore, no further source of

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1] This analysis of the budget focuses primarily upon the impact of the President's FY 1974 recommendations for the National Institutes of Health, and the Health Services and Mental Health Administration; however, data were also provided by the medical schools reflecting the anticipated levels of funding by other Federal agencies, such as the National Science Foundation, the Atomic Energy Commission, and the Department of Defense.

income to overcome the recommended 26 percent reduction in expenditures from Federal funds for fiscal year 1974 from the levels planned by the medical schools for their activities in the coming fiscal year.

. . . The overall impact of the proposed budget recommendations for fiscal 1974 is the same for both public and private medical schools, as shown by the data reported for this review. Both groups indicate a decline of 26 percent in expenditures from Federal funds from the levels previously planned for fiscal 1974. As in the past, however, Federal funds constitute a somewhat higher proportion of the total income for the private medical schools.

. . . For medical school faculty, the reduced levels of Federal support for fiscal year 1974 recommended in the President's budget will require the reporting seventy-eight medical schools to terminate the employment, or find other means of salary support for 1,400 faculty members whose activities are currently paid for from Federal funds. This represents a loss of one out of six faculty members who in the current year are paid from Federal funds (Table 2).

Reduced levels of employment would be required in fiscal 1974 for all activities supported by the Federal Government, with the sharpest decline in faculty employed on graduate and research training grants and the Regional Medical Program projects.

When account is taken of medical school faculty whose salaries are not paid from Federal grants or contracts, this loss may, at a minimum, represent one out of twelve faculty members.

. . . For the supporting staff, the President's budget recommendations for fiscal year 1974, if enacted, would result in a decline of more than 15 percent from current fiscal 1973 levels in the funds for the salaries of supporting staff, and a comparable reduction in the numbers of supporting staff employed in the research, training, and service activities of the medical schools, and a decline of 25 percent from the levels planned by the medical schools for fiscal 1974, prior to the release of the Federal budget.

Biomedical Research

. . . Fiscal year 1974 expenditures of Federal funds for research at the seventy-eight medical schools, as recommended in the President's budget will

. Remain at the levels provided two years ago for fiscal 1972 (Table 3),

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- Decline almost 10 percent from the estimated total for fiscal 1973, and

- Decline more than 15 percent from the levels planned by the medical schools prior to the release of the budget recommendations.

. . . However, Federal funds for new approaches to inquiry in the biomedical sciences will be less by 40 percent from the actual levels for fiscal 1972. In the best judgment of the sponsoring medical schools, there are innovative proposals of sufficient scientific competence and importance to merit support at amount levels equal to fiscal 1972 expenditures. The President's budget recommendations, however, would provide funds for about one out of two of these proposals.

. . . Medical schools also anticipate a reduction in fiscal year 1974, from the planned levels, of 10 percent in previously committed levels of support for research investigations that are not yet completed, and a 35 percent reduction in funds the schools had planned to request for fiscal year 1974 to carry forward the promising investigations whose term of approved and committed support will end in fiscal 1973.

Graduate and Research Training

. . . Federal funds for advanced training for careers in research and academic medicine have also been instrumental in strengthening the educational capabilities of medical school basic and clinical science departments. The President's Fiscal Year 1974 Budget recommendations for this activity represent a

- Decline of almost 40 percent from fiscal 1972 funds (Table 4), and a

- Decline of more than 40 percent from the levels planned by the medical schools prior to January 29.

. . . The number of students and support of faculty directly involved would also decline by comparable proportions.

Undergraduate Medical Education

. . . Undergraduate medical education programs in general, have been assisted by Federal funds made available on the basis of the numbers of medical students enrolled, and by specific

grants, to further some aspect of the educational capability of the medical school. The President's Fiscal Year 1974 Budget recommends that

- Funds based on the numbers of students enrolled be held at approximately the current fiscal 1973 level. This amount is more than 15 percent below the level the medical schools had planned on the basis of the increased student population they will enroll (Table 5).

- Funds for programs to advance undergraduate medical education be reduced about 15 percent below the fiscal year 1972 amount, more than 10 percent below the amounts expended in fiscal year 1973, and 35 percent below the levels planned by the schools for the continuation of these activities in fiscal year 1974.

Institutional Support Grants

. . . General Research Support Grants have provided a measure of institutional flexibility and capability to take quick advantage of new research opportunities, to assist new investigators, to provide a research experience for students, and to purchase equipment and other items for the shared use of several investigators.

Medical schools had originally planned their fiscal 1974 activities on the basis of a continuation of this support at about the fiscal 1972 level (Table 6). The President's Budget recommendations would provide about 30 percent of the anticipated support, an amount disastrously small for the objectives to be gained.

. . . The conduct of biomedical research requires extensive technological resources and the clinical settings for the controlled application of the findings of the on-going research investigations. Funds recommended in the President's Fiscal Year 1974 Budget would support this activity at approximately the current fiscal 1973 levels, but 15 percent below the amount planned by the medical schools for next year.

Regional Medical Programs

. . . The President's Budget recommends the elimination after June 30, 1973, of the Regional Medical Programs, with the possibility that some few projects almost completed may be continued after that date. Funds administered directly by the schools for these activities are shown in Table 7.

Table 1

EXPENDITURES OF SEVENTY-EIGHT MEDICAL SCHOOLS
BY SOURCE OF FUNDS, FY 1972-1974

ITEM	FY 1972 Actual	FY 1973 Current Estimate	FY 1974 Original estimate Prior to Jan. 29, 1973	FY 1974 Current estimate based on Pres. Budget
	(millions of dollars)			
Total, (78) schools	$1,549.2	$1,647.0	$1,842.7	$1,584.7
Federal funds	754.0	791.5	911.8	671.3
Other sources	795.2	855.5	930.9	913.4
State and local Appropriations	248.4	280.0	321.5	313.3
Private medical schools, total	767.3	821.9	914.7	783.7
Federal funds	395.6	428.5	498.0	370.5
Other sources	371.7	393.4	416.7	413.2
State and local Appropriations	25.8	30.6	34.5	34.2
Public medical schools, total	781.8	824.8	928.0	801.0
Federal funds	358.4	362.9	413.7	300.8
Other sources	423.4	461.9	514.3	500.2
State and local Appropriations	222.5	249.4	287.1	279.1

INDEX NUMBERS

	FY 1972 = 100				FY 1974 original estimate=100	
	FY 1972	FY 1973	FY 1974		FY 1974	
	Actual	Current Estimate	Original Estimate	Current Estimate	Original Estimate	Current Estimate
Total expenditures all (78) schools	100	106	119	102	100	86
Federal funds	100	105	121	89	100	74
Other sources	100	108	117	115	100	98
State and local Appropriations	100	113	129	126	100	97
Private medical schools, total	100	107	119	102	100	86
Federal funds	100	108	126	94	100	74
Other sources	100	106	112	111	100	99
State and local Appropriations	100	115	134	132	100	99
Public medical schools, total	100	106	119	102	100	86
Federal funds	100	101	115	84	100	73
Other sources	100	109	121	118	100	97
State and local Appropriations	100	112	129	125	100	97

NOTE: Table 8 presents additional detail.

Table 2

MEDICAL SCHOOL FACULTY EMPLOYED ON AND PAID FROM FEDERAL GRANTS AND CONTRACTS
SEVENTY-EIGHT MEDICAL SCHOOLS
FY 1972-1974

ITEM	FY 1972 Actual	FY 1973 Current Estimate	FY 1974 Original estimate Prior to Jan. 29, 1973	FY 1974 Current estimate based on Pres. Buduet
Total Faculty, Full-time,estimate	8,256	8,785	9,922	7,364
Research grants and contracts	3,418	3,431	3,828	3,210
Graduate and research training grants	1,815	1,700	1,771	921
Undergradute medical educ. grants	1,559	2,401	2,876	2,366
Institutional support grants	832	701	878	582
Regional medical programs	259	188	199	6
Medical service grants & contracts	373	364	370	279

INDEX NUMBERS

	FY 1972= 100				FY 1974 original estimate = 100	
			FY 1974		FY 1974	
	FY 1972 Actual	FY 1973 Current	Original Estimate	Current Estimate	Original Estimate	Current Estimate
Total faculty	100	106	120	89	100	74
Research grants and contracts	100	100	112	94	100	84
Graduate res. training grants	100	94	98	51	100	52
Undergraduate medical education	100	154	185	152	100	82
Institutional support grants	100	84	106	70	100	66
Regional medical programs	100	73	77	2	100	3
Medical service grants & contracts	100	98	99	75	100	75

NOTE: The estimate of full-time faculty is the sum of: (a) the number of faculty reported to receive total salary support from Federal grants or contracts; plus (b) 75 percent of the number reported to receive more than half, but less than total salary support from Federal grants or contracts; plus (c) 25 percent of the numbers reported to receive some but less than half of salary support from Federal grants or contracts.

The estimated number of faculty paid from regional medical program funds and Federal medical service grants and contracts was derived by applying the proportion of faculty salaries paid from these funds of the total faculty salaries (reported for regional medical programs and all medical service grants and contracts), to the aggregate faculty numbers reported by the medical schools to be paid from regional medical funds and all medical service grants and contracts.

Table 3

EXPENDITURES OF FEDERAL FUNDS FOR RESEARCH
BY SEVENTY-EIGHT MEDICAL SCHOOLS
FY 1972-1974

ITEM	FY 1972 Actual	FY 1973 Current Estimate	FY 1974 Original estimate Prior to Jan. 29, 1973	FY 1974 Current estimate based on Pres. Budget
		(millions of dollars)		
Total, grants and contracts	$371.8	$401.6	$446.3	$373.4
Research grants	293.1	315.8	358.6	291.7
New awards	46.9	45.9	47.2	28.7
Competitive renewals	53.3	52.8	70.6	45.9
Non-competitive renewals	192.8	217.1	240.7	217.2
Research contracts	78.7	85.8	87.8	81.7
Expenditures of research funds for:				
Faculty salaries	56.7	61.5	69.0	57.6
Other personnel salaries	121.1	132.0	144.7	122.1
Other direct & indirect costs	193.9	208.1	232.6	193.8

INDEX NUMBERS

	FY 1972= 100				FY 1974 original estimate=100	
	FY 1972	FY 1973	FY 1974		FY 1974	
	Actual	Current Estimate	Original Estimate	Current Estimate	Original Estimate	Current Estimate
Total grants & contracts	100	108	120	100	100	84
Research grants	100	108	122	100	100	81
New awards	100	98	101	61	100	61
Competitive renewals	100	99	132	86	100	65
Non-competitive renewals	100	113	125	113	100	90
Research contracts	100	109	111	104	100	93
Faculty salaries	100	108	122	101	100	83
Other personnel salaries	100	109	119	101	100	84
Other direct & indirect costs	100	107	120	100	100	83

Table 4

EXPENDITURES OF FEDERAL FUNDS FOR GRADUATE AND RESEARCH TRAINING AND NUMBER OF STUDENTS TRAINED BY SEVENTY-EIGHT MEDICAL SCHOOLS FY 1972-1974

ITEM	FY 1972 Actual	FY 1973 Current Estimate	FY 1974 Original Estimate Prior to Jan. 29, 1973	FY 1974 Current estimate based on Pres. Budget
	(millions of dollars)			
Total, training grants	$125.0	117.8	$ 133.7	$ 78.1
Faculty salaries	28.7	27.1	30.6	17.0
Other personnel salaries	16.8	16.5	18.9	11.0
Student stipends	48.1	44.6	50.4	30.7
Other direct & indirect costs	31.4	29.6	33.8	19.4
Numbers of students trained, total	12,082	10,787	13,220	7,459
Predoctoral	4,887	4,111	5,434	2,710
Postdoctoral	4,741	4,266	4,818	2,864
Other	2,454	2,410	2,968	1,885

INDEX NUMBERS

	FY 1972 = 100				FY 1974 original estimate=100	
	FY 1972	FY 1973	FY 1974		FY 1974	
	Actual	Current Estimate	Original Estimate	Current Estimate	Original Estimate	Current Estimate
Total, training grants	100	94	107	62	100	58
Faculty salaries	100	95	107	59	100	55
Other personnel salaries	100	98	113	66	100	58
Student stipends	100	93	105	64	100	61
Other direct & indirect costs	100	94	108	62	100	57
Numbers of students trained	100	89	109	62	100	56
Predoctoral	100	84	111	56	100	50
Postdoctoral	100	90	102	60	100	59
Other	100	98	121	77	100	64

Table 5

EXPENDITURES OF FEDERAL FUNDS FOR SUPPORT OF UNDERGRADUATE MEDICAL EDUCATION BY SEVENTY-EIGHT MEDICAL SCHOOLS FY 1972-1974

ITEM	FY 1972 Actual	FY 1973 Current Estimate	FY 1974 Original Estimate Prior to Jan. 29, 1973	FY 1974 Current estimate based on Pres. Budget
	(millions of dollars)			
Capitation grants	$28.3	$62.5	$77.5	$65.0
Special project grants excluding financial distress grants	$34.0	$33.4	$44.9	$29.6
Physician augmentation	19.7	17.5	23.6	15.6
Curriculum improvement	8.4	5.4	7.4	4.7
Enrollment of minority students	.8	2.2	2.6	1.7
Other	5.1	8.3	11.3	7.6
Financial distress grants	7.7	3.8	3.7	1.2

INDEX NUMBERS

	FY 1972= 100				FY 1974 original estimate=100	
	FY 1972	FY 1973	FY 1974		FY 1974	
	Actual	Current Estimate	Original Estimate	Current Estimate	Original Estimate	Current Estimate
Capitation grants	100	220	273	229	100	84
Special project grants	100	98	132	87	100	66
Physician augmentation	100	89	120	79	100	66
Curriculum improvement	100	64	88	56	100	64
Enrollment of minority students	100	269	321	210	100	65
Other	100	163	221	149	100	67
Financial distress	100	49	48	15	100	31

Table 6

EXPENDITURES OF FEDERAL FUNDS FROM INSTITUTIONAL SUPPORT GRANTS
BY SEVENTY-EIGHT MEDICAL SCHOOLS
FY 1972-1974

ITEM	FY 1972 Actual	FY 1973 Current Estimate	FY 1974 Original Estimate Prior to Jan. 29, 1973	FY 1974 Current Estimate based on Pres. Budget
	(millions of dollars)			
Total expenditures	$79.5	$74.3	$94.1	$71.0
General research support grants	18.1	10.5	17.4	5.1
Resource and special centers	61.4	63.9	76.7	66.0
Expenditures of institutional support grant funds for				
Faculty salaries	16.9	15.1	20.0	13.4
Other personnel salaries	23.3	22.8	27.3	21.9
Equipment	7.2	6.1	8.3	5.3
Other	32.1	30.3	38.5	30.4

INDEX NUMBERS

	FY 1972= 100				FY 1974 original estimate=100	
	FY 1972	FY 1973	FY 1974		FY 1974	
	Actual	Current Estimate	Original Estimate	Current Estimate	Original Estimate	Current Estimate
Total expenditures	100	94	118	89	100	76
General research support grants	100	58	96	28	100	29
Resource and special centers	100	104	125	107	100	86
Faculty salaries	100	90	119	80	100	67
Other personnel salaries	100	98	117	94	100	80
Equipment	100	85	115	73	100	64
Other	100	95	120	95	100	79

Table 7

EXPENDITURES OF FEDERAL FUNDS FOR REGIONAL MEDICAL PROGRAMS
BY SEVENTY-EIGHT MEDICAL SCHOOLS
FY 1972-1974

ITEM	FY 1972 Actual	FY 1973 Current Estimate	FY 1974 Original Estimate Prior to Jan. 29, 1973	FY 1974 Current Estimate based on Pres. Budget
		(millions of dollars)		
Total	$42.1	$30.8	$37.2	$1.7
Faculty salaries	5.2	3.9	4.4	.1
Other personnel salaries	14.8	10.9	12.2	.6
Other direct & indirect costs	22.1	16.0	20.6	1.0

Table 8

SOURCES OF FUNDS SEVENTY-EIGHT MEDICAL SCHOOLS
FY 1972-1974

ITEM	FY 1972 Actual	FY 1973 Current Estimate	FY 1974 Original Estimate Prior to Jan. 29, 1973	FY 1974 Current Estimate
		(millions of dollars)		
Total	$1,549.2	$1,647.0	$1,842.7	$1,584.7
Federal, total	754.0	791.5	911.8	671.3
Research grants	293.1	315.8	358.6	291.7
Research contracts	78.7	85.8	87.8	81.7
Research training grants	125.0	117.8	133.7	78.1
Fellowships & career awards	20.1	19.0	18.9	13.8
Capitation grants	28.3	62.5	77.5	65.0
Special project grants	41.7	37.1	48.6	30.8
General research support grants	18.1	10.5	17.4	5.1
Resource and special grants	61.4	63.9	76.7	65.9
Regional medical programs	42.1	30.8	37.2	1.7
Medical service grants & contracts	33.6	34.8	36.7	23.4
Other	11.9	13.5	18.8	14.1
State & local, total	369.0	400.7	446.5	433.8
Appropriations	248.4	280.0	321.5	313.3
Medical service grants & contracts	57.8	58.1	62.4	57.8
Other	62.8	62.6	62.6	62.7
Other, total	426.2	454.8	484.4	479.6
Sponsored research	91.8	95.6	98.7	97.7
Sponsored teaching	34.5	36.1	39.7	37.4
Tuition & fees	52.6	59.8	65.6	65.7
Medical service plan income	112.1	121.2	129.9	127.3
Endowment income	31.8	36.5	39.4	39.6
Gifts	29.9	31.7	31.8	32.3
Other	73.5	73.9	79.3	79.6

APPENDIX

Estimates of the impact of the proposed Federal budget as reported by seventy-eight medical schools in terms of the research and graduate education programs administered by the major components of the National Institutes of Health, the National Institute of Mental Health, other components of the Health Services and Mental Health Administration, and all other Federal agencies are presented in the following Tables.

NATIONAL HEART AND LUNG INSTITUTE, NIH

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel,
For Seventy-Eight Medical Schools
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	% Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	% Change Over FY'74 Orig. Estimate
Regular Research Grants, Total Expenditures	$58.4	+ 6.5%	- 0.7%	- 8.7%
New Awards, Total	$ 5.4	-32.7	- 0.9	-18.3
Research Contracts, Total Expenditures	$19.1	+37.2	+ 4.4	- 7.2
Faculty Salaries	$11.8	+18.0	+ 1.7	- 6.6
Personnel				
Faculty, Total FTE	649	+ 5.7	+ 0.9	- 5.8
Supporting Staff, Total Employed on These Research Grants and Contracts	3,410	- 6.2	- 6.0	- 8.1

* Grants to Support Investigator-Initiated Research

NATIONAL CANCER INSTITUTE, NIH

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel,
For Seventy-Eight Medical Schools
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	% Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	% Change Over FY'74 Orig. Estimate
Regular Research Grants, Total Expenditures	$50.5	+46.4%	+12.1%	- 5.3%
New Awards, Total	$ 8.2	+ 4.2	-18.5	-17.0
Research Contracts, Total Expenditures	$19.3	+ 6.5	+ 4.0	- 1.1
Faculty Salaries	$ 9.6	+44.7	+ 9.1	- 4.3
Personnel				
Faculty, Total FTE	584	+37.7	+20.2	- 3.8
Supporting Staff, Total Employed on These Research Grants and Contracts	2,940	+15.5	+ 2.0	- 2.4

* Grants to Support Investigator-Initiated Research

NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM AND DIGESTIVE DISEASES, NIH

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel,
For Seventy-Eight Medical Schools
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	% Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	% Change Over FY'74 Orig. Estimate
Regular Research Grants, Total Expenditures	$39.5	-10.8%	-11.5%	-22.5%
New Awards, Total	$ 2.7	-48.4	-33.1	-55.2
Research Contracts, Total Expenditures	$ 1.4	-10.0	-16.4	-17.3
Faculty Salaries	$ 5.9	-10.1	- 8.0	-23.1
Personnel				
Faculty, Total FTE	699	-16.6	-10.8	-21.1
Supporting Staff, Total Employed on These Research Grants and Contracts	2,140	-17.5	-13.0	-18.9

* Grants to Support Investigator-Initiated Research

NATIONAL INSTITUTE OF NEUROLOGICAL DISEASES AND STROKE, NIH

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel,
For Seventy-Eight Medical Schools
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	% Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	% Change Over FY'74 Orig. Estimate
Regular Research Grants, Total Expenditures	$26.3	- 8.0%	- 6.5%	-24.2%
New Awards, Total	$ 2.9	- 7.8	-25.0	-43.4
Research Contracts, Total Expenditures	$ 2.6	+ 2.3	- 7.6	-10.3
Faculty Salaries	$ 5.3	- 0.7	- 4.0	-19.6
Personnel				
Faculty, Total FTE	268	-12.7	- 8.2	-23.6
Supporting Staff, Total Employed on These Research Grants and Contracts	1,364	-17.3	-10.4	-19.3

* Grants to Support Investigator-Initiated Research

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NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, NIH

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel,
For Seventy-Eight Medical Schools
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	% Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	% Change Over FY'74 Orig. Estimate
Regular Research Grants, Total Expenditures	$17.3	- 9.9%	-10.1%	-20.7%
New Awards, Total	$ 1.0	-59.5	-48.7	-57.2
Research Contracts, Total Expenditures	$ 2.3	-10.0	- 9.0	- 9.4
Faculty Salaries	$ 2.1	-12.3	- 8.4	-22.8
Personnel				
Faculty, Total FTE	116	-16.5	- 9.4	-21.6
Supporting Staff, Total Employed on These Research Grants and Contracts	974	-18.6	-12.5	-13.3

* Grants to Support Investigator-Initiated Research

NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCE, NIH

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel,
For Seventy-Eight Medical Schools
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	% Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	% Change Over FY'74 Orig. Estimate
Regular Research Grants, Total Expenditures	$23.1	- 5.4%	-17.9%	-26.7%
New Awards, Total	$ 0.8	-74.3	-80.6	-59.3
Research Contracts, Total Expenditures	$ 1.4	+43.4	+ 2.5	+ 7.1
Faculty Salaries	$ 3.3	- 9.0	-17.1	-27.9
Personnel				
Faculty, Total FTE	207	-10.8	-14.8	-23.3
Supporting Staff, Total Employed on These Research Grants and Contracts	1,172	-11.9	-13.4	-20.9

* Grants to Support Investigator-Initiated Research

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT, NIH

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel,
For Seventy-Eight Medical Schools
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	% Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	% Change Over FY'74 Orig. Estimate
Regular Research Grants, Total Expenditures	$16.8	+ 1.4%	- 9.5%	-22.7%
New Awards, Total	$ 1.2	-71.0	-66.7	-60.1
Research Contracts, Total Expenditures	$ 3.9	+ 8.3	-12.4	-17.2
Faculty Salaries	$ 3.4	- 0.4	-13.0	-24.7
Personnel				
Faculty, Total FTE	193	-11.9	-13.1	-19.2
Supporting Staff, Total Employed on These Research Grants and Contracts	1,012	-11.5	-12.9	-18.4

* Grants to Support Investigator-Initiated Research

NATIONAL INSTITUTE OF MENTAL HEALTH, HSMHA

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel,
For Seventy-Eight Medical Schools
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	% Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	% Change Over FY'74 Orig. Estimate
Regular Research Grants, Total Expenditures	$16.7	-20.5%	-22.4%	-30.4%
New Awards, Total	$ 2.7	-39.3	-14.8	-43.6
Research Contracts, Total Expenditures	$ 1.4	-19.9	-33.3	-18.9
Faculty Salaries	$ 2.7	-28.4	-29.9	-29.9
Personnel				
Faculty, Total FTE	167	-27.0	-24.0	-30.0
Supporting Staff, Total Employed on These Research Grants and Contracts	1,004	-28.5	-26.4	-25.9

* Grants to Support Investigator-Initiated Research

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
COMPONENTS EXCEPT NIMH

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel,
For Seventy-Eight Medical Schools
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	% Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	% Change Over FY'74 Orig. Estimate
Regular Research Grants, Total Expenditures	$ 6.6	- 7.9%	-10.4%	-22.1%
New Awards, Total	$ 0.5	-54.7	-70.5	-56.4
Research Contracts, Total Expenditures	$ 5.7	- 6.5	- 6.4	- 2.0
Faculty Salaries	$ 1.6	-22.0	-12.5	-17.8
Personnel				
Faculty, Total FTE	96	-14.5	-14.5	-17.5
Supporting Staff, Total Employed on These Research Grants and Contracts	40	-23.4	-19.6	-14.2

* Grants to Support Investigator-Initiated Research

FEDERAL AGENCIES - OTHER THAN NIH AND HSMHA

REGULAR* RESEARCH GRANTS AND RESEARCH CONTRACTS
Operating Expenditures and Number of Personnel,
For Seventy-Eight Medical Schools
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	% Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	% Change Over FY'74 Orig. Estimate
Regular Research Grants, Total Expenditures	$20.0	-16.9%	-16.8%	-20.9%
New Awards, Total	$ 2.2	-53.8	-50.5	-41.9
Research Contracts, Total Expenditures	$22.4	-12.9	-11.4	- 6.8
Faculty Salaries	$ 8.5	-11.0	- 8.9	-14.5
Personnel				
Faculty, Total FTE	427	-24.6	-14.3	-18.4
Supporting Staff, Total Employed on These Research Grants and Contracts	1,975	-27.2	-18.3	-15.6

* Grants to Support Investigator-Initiated Research

NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM AND DIGESTIVE DISEASES, NIH

RESEARCH TRAINING GRANTS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	%Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	%Change Over FY'74 Orig. Estimate
Research Training grants, total expenditures	$ 6.1	-46.5%	-37.6%	-45.7%
Faculty Salaries	$ 0.9	-51.5	-42.5	-49.2
Student Stipends	$ 2.9	-43.7	-34.5	-42.5
Career Awards, total salaries	$ 1.6	-18.3	-18.6	-16.8
Personnel and Students				
Faculty, total FTE	51	-57.1	-46.0	-50.0
Supporting staff, total employed on these grants	171	-49.1	-35.7	-43.4
Students trained, total number	367	-49.3	-42.7	-48.7
Students trained, predoctoral	35	-71.3	-68.5	-72.2
Students trained, postdoctoral	324	-43.6	-36.5	-41.0
Research Career Awards, total number	78	-15.2	-18.8	-16.1

NATIONAL INSTITUTE OF NEUROLOGICAL DISEASES AND STROKE, NIH

RESEARCH TRAINING GRANTS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	%Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	%Change Over FY'74 Orig. Estimate
Research Training grants, total expenditures	$ 5.4	-34.3%	-29.7%	-34.3%
Faculty Salaries	$ 1.4	-38.1	-35.2	-36.6
Student Stipends	$ 2.1	-26.0	-20.5	-29.3
Career Awards, total salaries	$ 0.8	-33.1	-24.4	-23.5
Personnel and Students				
Faculty, total FTE	75	-42.3	-35.9	-37.0
Supporting staff, total employed on these grants	157	-51.4	-44.5	-44.5
Students trained, total number	440	-27.4	-21.0	-28.0
Students trained, predoctoral	70	-39.1	-20.4	-34.0
Students trained, postdoctoral	346	-26.2	-21.5	-27.0
Research Career Awards, total number	37	-35.1	-28.8	-24.5

RESEARCH TRAINING GRANTS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	%Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	%Change Over FY'74 Orig. Estimate
Research Training grants, total expenditures	$ 5.4	-25.8%	-28.7%	-44.1%
Faculty Salaries	$ 1.1	-18.0	-27.9	-43.6
Student Stipends	$ 2.4	-23.4	-25.9	-43.7
Career Awards, total salaries	$ 0.7	- 7.8	-26.8	-27.8
Personnel and Students				
Faculty, total FTE	70	-17.4	-28.3	-38.1
Supporting staff, total employed on these grants	161	-19.9	-21.1	-34.0
Students trained, total number	590	-35.4	-27.0	-59.9
Students trained, predoctoral	157	-61.4	-18.7	-72.8
Students trained, postdoctoral	214	-40.2	-30.3	-54.9
Research Career Awards, total number	34	- 8.1	-22.7	-26.1

NATIONAL HEART AND LUNG INSTITUTE, NIH

RESEARCH TRAINING GRANTS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	%Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	%Change Over FY'74 Orig. Estimate
Research Training grants, total expenditures	$ 6.8	-39.6%	-31.0%	-37.2%
Faculty Salaries	$ 1.3	-36.2	-28.3	-34.9
Student Stipends	$ 3.1	-36.7	-30.4	-36.4
Career Awards, total salaries	$ 2.3	-16.0	-14.8	-12.4
Personnel and Students				
Faculty, total FTE	85	-39.7	-30.3	-34.1
Supporting staff, total employed on these grants	190	-43.1	-29.4	-34.0
Students trained, total number	493	-38.4	-29.2	-35.3
Students trained, predoctoral	130	-49.2	-31.6	-40.9
Students trained, postdoctoral	350	-32.0	-27.1	-31.8
Research Career Awards, total number	91	-16.5	-15.7	-12.5

RESEARCH TRAINING GRANTS, RESEARCH CAREER AWARDS

Operating Expenditures and Number of Personnel
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	%Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	%Change Over FY'74 Orig. Estimate
Research Training grants, total expenditures	$ 2.9	-38.9%	-36.2%	-42.1%
Faculty Salaries	$ 0.3	-41.4	-36.6	-42.0
Student Stipends	$ 1.3	-39.8	-37.3	-43.3
Career Awards, total salaries	$ 1.0	-33.1	-24.4	-23.0
Personnel and Students				
Faculty, total FTE	20	-42.9	-35.5	-35.5
Supporting staff, total employed on these grants	71	-48.2	-41.3	-42.7
Students trained, total number	291	-42.1	-40.2	-42.6
Students trained, predoctoral	184	-35.9	-31.1	-35.2
Students trained, postdoctoral	99	-52.9	-51.7	-52.4
Research Career Awards, total number	42	-36.4	-28.8	-23.6

NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCE, NIH

RESEARCH TRAINING GRANTS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	%Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	%Change Over FY'74 Orig. Estimate
Research Training grants, total expenditures	$13.5	-35.9%	-31.7%	-40.1%
Faculty Salaries	$ 1.1	-43.7	-34.8	-49.1
Student Stipends	$ 6.5	-32.2	-29.8	-35.8
Career Awards, total salaries	$ 2.7	-17.6	-18.0	-17.6
Personnel and Students				
Faculty, total FTE	65	-47.2	-35.6	-46.7
Supporting staff, total employed on these grants	233	-43.9	-34.6	-41.8
Students trained, total number	1,476	-33.5	-26.9	-34.1
Students trained, predoctoral	1,137	-30.8	-25.1	-32.2
Students trained, postdoctoral	339	-39.9	-31.0	-38.6
Research Career Awards, total number	118	-19.7	-20.3	-18.6

RESEARCH TRAINING GRANTS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	%Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	%Change Over FY'74 Orig. Estimate
Research Training grants, total expenditures	$ 2.6	-38.1%	-31.3%	-37.6%
Faculty Salaries	$ 0.5	-37.1	-23.8	-35.2
Student Stipends	$ 1.2	-34.5	-28.3	-33.4
Career Awards, total salaries	$ 0.9	-31.8	-20.6	-15.1
Personnel and Students				
Faculty, total FTE	21	-40.0	-30.0	-41.7
Supporting staff, total employed on these grants	51	-39.3	-35.4	-40.0
Students trained, total number	221	-36.1	-30.3	-34.8
Students trained, predoctoral	97	-37.4	-32.2	-26.5
Students trained, postdoctoral	120	-35.8	-31.0	-40.9
Research Career Awards, total number	37	-36.2	-26.0	-15.9

BUREAU OF HEALTH MANPOWER AND EDUCATION, NIH

RESEARCH TRAINING GRANTS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	%Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	%Change Over FY'74 Orig. Estimate
Research Training grants, total expenditures	$ 4.7	-31.0%	-41.8%	-55.4%
Faculty Salaries	$ 1.4	-44.6	-44.8	-59.7
Student Stipends	$ 0.8	-40.6	-42.9	-51.7
Career Awards, total salaries				
Personnel and Students				
Faculty, total FTE	53	-74.5	-68.3	-78.9
Supporting staff, total employed on these grants	212	-28.4	-37.3	-52.0
Students trained, total number	504	-34.9	-34.2	-56.7
Students trained, predoctoral	223	-42.1	-41.6	-68.1
Students trained, postdoctoral	51	-34.2	-21.5	-23.9
Research Career Awards, total number				

NATIONAL INSTITUTE OF MENTAL HEALTH, HSMHA

RESEARCH TRAINING GRANTS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	%Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	%Change Over FY'74 Orig. Estimate
Research Training grants, total expenditures	$14.0	-51.7%	-46.6%	-52.5%
Faculty Salaries	$ 4.4	-54.7	-52.3	-55.7
Student Stipends	$ 5.5	-50.3	-42.8	-50.6
Career Awards, total salaries	$ 1.3	-26.9	-26.5	-26.7
Personnel and Students				
Faculty, total FTE	240	-59.5	-53.8	-56.4
Supporting staff, total employed on these grants	300	-61.9	-54.5	-56.4
Students trained, total number	1,566	-49.6	-41.5	-52.1
Students trained, predoctoral	256	-71.9	-62.0	-73.6
Students trained, postdoctoral	657	-49.9	-41.5	-49.9
Research Career Awards, total number	54	-19.4	-22.9	-20.6

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
COMPONENTS EXCEPT NIMH

RESEARCH TRAINING GRANTS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	%Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	%Change Over FY'74 Orig. Estimate
Research Training grants, total expenditures	$ 9.2	-10.1%	-11.3%	-12.7%
Faculty Salaries	$ 2.8	- 7.4	- 6.6	- 8.6
Student Stipends	$ 2.9	- 6.6	- 5.4	- 6.5
Career Awards, total salaries	$ 0.04	-35.8	-25.9	-29.5
Personnel and Students				
Faculty, total FTE	138	-20.2	-11.0	-10.4
Supporting staff, total employed on these grants	224	-21.7	-15.8	-14.5
Students trained, total number	325	-22.1	-16.7	-16.9
Students trained, predoctoral	163	- 9.4	-22.7	-23.5
Students trained, postdoctoral	133	-17.4	- 5.0	- 7.0
Research Career Awards, total number	2.	- 0.0	- 0.0	- 0.0

RESEARCH TRAINING GRANTS, RESEARCH CAREER AWARDS
Operating Expenditures and Number of Personnel
(All Dollar Amounts in Millions)

Type of Awards and Object of Expenditure	FY'74 Present Estimate	%Change Over FY'72 Actual Amt.	% Change Over FY'73 Present Amt.	%Change Over FY'74 Orig. Estimate
Research Training grants, total expenditures	$ 4.3	-35.1%	-28.9%	-27.3%
Faculty Salaries	$ 1.2	-35.4	-30.3	-29.2
Student Stipends	$ 0.9	-40.5	-30.1	-28.9
Career Awards, total salaries	$ 0.0	-100.0	0.0	0.0
Personnel and Students				
Faculty, total FTE	64	-42.9	-30.4	-31.2
Supporting staff, total employed on these grants	123	-53.2	-36.6	-33.2
Students trained, total number	976	-28.3	-14.4	-30.3
Students trained, predoctoral	199	-39.9	-23.8	-37.6
Students trained, postdoctoral	80	-42.9	-27.9	-24.5
Research Career Awards, total number	0	-100.0	0.0	0.0

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Chairman Humphrey. I would like to proceed now, if I may, by going to our next witness and then for the general questioning we might come back and see if we can get a little panel discussion on some of these items.

The next witness is Mrs. Karen Davis, of the research association of Brookings Institution and assistant professor at Rice University, amongst other professional titles and competence.

We welcome you and thank you very much for coming, and proceed with your testimony.

If you would like to have your entire prepared statement entered in the record, and then paraphrase it, you are at liberty to do so. Or you can read your prepared statement; it is your choice, whatever is most comfortable.

STATEMENT OF KAREN DAVIS, RESEARCH ASSOCIATE, THE BROOKINGS INSTITUTION

Mrs. Davis. Thank you for the opportunity to testify on the Federal role in financing medical services for the American people.

I have prepared a somewhat longer prepared statement for the record and will report the highlights here.

Since the administration has proposed several major changes in financing programs, I have organized my oral statement around three questions:

One. What deficiencies in financing medical services for all Americans exist even with current programs?

Two. Are the changes in these programs which have been proposed the most effective way of meeting these deficiencies?

Three. What problems in the medical care system are unlikely to be solved by even the best financing arrangements?

Since the mid-1960's the Federal Government has played a major role in financing individual medical care services through the medicare and medicaid programs. In addition to these well-known programs, the Federal Government subsidizes the purchase of health insurance and the payment of medical expenses through special tax provisions.

As shown in table 1 of my prepared statement, medicaid and medicare go primarily to the low-income groups, tax subsidies by contrast give only a little relief to the poor, being concentrated much more heavily upon upper income groups.

If you combine these in 1970, they amounted to $14 billion; 45 percent of that went to individuals with family incomes of less than $5,000. This concentration on the poor, however, is largely attributable to benefits for older people.

For the under 65 age group, the Federal Government in 1970 spent $5 billion on this age group. Only 28 percent went to individuals with incomes under $5,000, while 40 percent went to individuals with incomes above $10,000.

Payment of services for middle and upper income families therefore, substantially exceeds that made on behalf of the nonelderly poor by the Federal Government.

Current Federal programs help millions of people pay for medical care, but they have three major flaws:

(1) they are extremely uneven in coverage and benefits;

(2) they provide little protection against catastrophic medical expenses;

(3) the tax subsidy program offers large benefits to the rich and little to the poor.

Relative to other groups the elderly have been treated generously under Federal health financing programs. Medicare provides substantial benefits for hospital and physician care for retired persons covered by social security no matter where they live or what their income. In addition, a substantial portion of medical money in some States is spent for medical services to impoverished old people covered by medicaid.

These programs do not, however, relieve old people of all medical expenses. Indeed, the elderly now pay more for medical care out-of-pocket than before the inception of the medicare program in 1966.

Chairman HUMPHREY. That statement, the elderly pay more out out-of-pocket than before the inception of the medicare program, that is kind of a grabber. It is a startling statement.

How do you justify that? I don't doubt that you can, but how do you do it?

Mrs. DAVIS. The elderly now pay about $400 per person compared to $300 back in 1966, and of course, the major reason is the inflation in medical costs that has affected all age groups.

Without medicare, the elderly would be paying much more, so it isn't that they are not getting benefits but they are facing high prices.

I will explain some of the gaps in the medicare program that give rise to this:

High out-of-pocket expenses of the elderly are partly attributable to the fact that medicare does not protect old people from the expenses of prolonged hospitalization or extremely serious illness.

Patient charges on long hospital stays and limitations on covered days of hospital care raise costs to the patient. Under the physician portion of medicare, individuals must pay 20 percent of the physician charge even if the charge runs into many thousands of dollars. Other benefits such as private duty nursing care and out-of-hospital drugs are not covered at all. If an elderly individual is sick enough for long enough, he may incur bankrupting out-of-pocket costs.

Under medicaid, low-income individuals in some geographical areas have complete protection against virtually all medical expenses while low-income individuals in other geographical areas have only limited medicaid benefits. Forty-six percent of poor individuals live in the South, yet only 17 percent of medicaid payments go to individuals in that area. Three States, New York, Massachusetts, and California, spend 50 percent of all medicaid funds. Many poor individuals receive no coverage from medicaid—such as the working poor, childless couples, and low-income families with an unemployed father in States which do not provide cash assistance for such families.

Existing tax subsidies for health insurance and medical expenses also contain a number of deficiencies. First, they channel large amounts of Federal revenues to middle and upper income persons for health insurance premiums—expenses which could be met by most upper income persons without undue financial burden. Second, tax provisions covering direct medical expenses do not adequately protect individuals from catastrophic expenses. For example, if a family with income of $10,000

incurred $4,000 of medical expenses, its taxes would be reduced by $703. While it is some compensation, it is far from adequate protection against excessive medical bills.

Third, the deduction mechanism is an inequitable method of compensating individuals for financial losses from catastrophic medical expenses.

For example, if a family with income of $40,000 incurred the same $4,000 of medical expenses, its taxes would be reduced by $1,176—compared with only $700 for a family with $10,000 income. The Federal Government "pays" a higher share of the medical expenses of the family whose income is four times as high, and who presumably could better afford the $4,000 expenditure. In short, tax deductions do not meet the needs of either the poor or the middle income class. For the former, they provide little assistance at all. For the latter they help pay for normal medical expenses—which are not a burden—and do little to help pay for catastrophic expenses, which are the real medical problem for middle income families.

Chairman HUMPHREY. One thing that I noted in discussing these programs with some people was the fact that physical examinations are not included either under medicare or medicaid, and therefore when a person, in order to get medicare, of course, you have to go to the hospital.

There is no outpatient medicare as such. You have to go to the hospital.

When you ge to the hospital there is no health profile of many of these elderly people. There isn't any physical evamination records over the years to give some indication of what the normalities of that person may be.

For example, generally, what we study and what happens in medicine is we treat the abnormalities but to get the normalities it takes a good deal of time.

Our astronauts, for example, this morning, I was listening this morning about skylab. I was involved as Chairman of the Space Council.

One thing we took some pride in is we have a health profile on every astronaut for years so we know what his normalities are and therefore, if anything shows up on any type of testing we have a baseline to check by.

Most of the normalities today in medicine are generalities and there are no generalities about individuals, really.

Every individual is different, even in terms of—surely in terms of metabolism, surely in terms of heartbeats.

What is normal for one is not normal at all for another.

If a person has a heartbeat of let us say 60 over a period of years, that is normal for that person. Another may be 80 and that is normal, and we don't have that kind of records for elderly people because many of the elderly people covered under medicare really came from a culture that really didn't do much about medicine.

I remember my own mother, bless her memory, the first time she was ever in the hospital, she was about 70 years of age, and she wasn't about to tell the doctor a lot of things he wanted to know.

I remember mom saying to him, "Well, you are paid to find out."

They don't like to fill out all those blanks. If you go to one of these medicare facilities and see the elderly come in they resent having to

fill out all that stuff that the Government wants or that you have to fill out at the hospital, all that probing into how old you are and did you ever have this or ever have that. They figure that is none of your business.

Of course, the Government thinks they have a right to wiretap and do everything else these days. Your business is everybody's business now.

What I am getting at is, don't you think under medicare and medicaid, we ought to include physical examinations, health examinations? Isn't that a cost item?

Mrs. Davis. Right. This is becoming a more expensive item over time. I am sure it adds to the out-of-pocket cost.

Chairman Humphrey. It is sort of like a motor tuneup, you know, using a different metaphor. If you take your car in to get a motor tuneup, it used to cost 20 bucks, they used to advertise it for $12 around here in Washington.

Now they want $60, $80, $120, depending on how much they tune you up.

That isn't mechanical surgery, hardly replacement of parts. But now when you come in to get a physical examination today, what does it run, Dr. Cooper, a real first-class one?

Dr. Cooper. Well, along with the laboratory work which should be done to round out the valuation of the patient, probably costs some place around $125.

Chairman Humphrey. And maybe the best money, the wisest investment that you can make from the terms of cost of medical care, both of preventive medicine as well as curative medicine.

I just want to toss that in because I intend to get the law amended to provide medicaid and medicare to include physical examinations.

Medicaid may in some States, as you have indicated, States like Massachusetts, California, New York, have been more generous in medicaid than some other States, but in medicare I know it is not covered.

Mrs. Davis. I would like to turn to some of the changes the administration is proposing in each of these programs.

Under medicare the administration's budget calls for the elderly to pay a larger share of hospital and physician bills. Coinsurance under the physician portion, is to be increased from 20 percent to 25 percent and the deductible increase from $60 to $85.

Chairman Humphrey. Is that 85 or 80?

Mrs. Davis. $85. This change will result in substantially higher costs for all medicare beneficiaries using physicians' services.

Under the hospital part of medicare, present payments will be replaced by a requirement that all individuals pay 10 percent of the total charges for hospital care for all covered days. Most medicare beneficiaries with hospital stays of 100 or more days would face somewhat lower charges than under current law and for very long stays the reduction in charges would be quite significant. However, since 99 percent of all medicare hospital stays are less than 100 days in length, most medicare patients would be required to pay higher charges.

The administration estimates that these changes in medicare law will reduce Federal expenditures by $500 million in fiscal year 1974 and $1.3 billion in 1975, the first full year covered by change.

Chairman HUMPHREY. Which is just another way of saying that it is going to be saddled on the people who can least afford to pay it.

The largest group in this country are the poor. They are not to be identified racially, but by age and a large number of those poor are found in rural America where the incomes are abysmally low.

I have forgotten the percentages, but some years back, I remember 50 percent of the elderly of age 65 or over that had incomes of $1,600 a year, very, very low income level.

When you saddle additional costs on them as a group, you really put a terrible burden upon a large number of people.

Now, there may be individuals in that group that could well pay that additional charge. That is why it is so difficult to make generalizations about these medical programs, or put it another way, when you write law that generally overall makes increases, it may be that 10 percent of the persons affected can well afford those increased governmental requirements, but for 90 percent of them it will be a personal hardship.

Mrs. DAVIS. You are correct that these changes in medicare will fall very heavily upon a group which has predominantly low incomes.

In 1970, for example, 60 percent of elderly individuals were in families with incomes below $5,000.

These proposed changes are particularly inappropriate, because, one, they are not related to income;

Two, they contain no ceiling on coinsurance payments; and

Three, savings generated by the coinsurance provisions are not used to provide better protection against catastrophic expenses such as an increase in covered hospital days or coverages of out-of-hospital prescription drugs.

Any discussion of cost-sharing provisions must be in the context of reasonable ability to pay such charges. Few elderly individuals have sufficient incomes to pay sizable coinsurance amounts; only 18 percent of the elderly had family incomes above $10,000 in 1970.

In addition, the elderly already pay twice as much out of pocket for medical services as other population groups. Under proposed legislation, an elderly couple with one member hospitalized for 30 days and physician bills of $2,000 could expect to pay medical expenses of at least $1,500 (including medicare premiums, noncovered benefits such as drugs, and normal medical expenses for the other family member). Most would agree that such an out-of-pocket payment is excessive for any family with income below $10,000—or about 82 percent of all elderly individuals.

Turning to the tax subsidy plan, the administration has proposed changes in this one as well.

In testimony before the House Ways and Means Committee on April 30, 1973, Secretary of Treasury Shultz indicated that as part of a personal income tax simplification plan, the administration proposes elimination of the special treatment of individual health insurance expenses. In its place is a single deduction for all medical expenses, health insurance premiums, and casualty losses; an itemized deduction would be permitted only to the extent that the combined total exceeds a floor equal to 5 percent of the taxpayer's adjusted gross income. No change in tax treatment of employer contributions to health insurance premiums is proposed.

While this change has the effect of reducing tax subsidies for medical expenses—which go in large part to higher income groups—inequities arising from the greater value of a deduction to higher income individuals would still be present.

A still better alternative would be to replace all existing tax benefits for health insurance and medical expenses with a tax credit for all medical expenses in excess of some percentage of income. For example, taxes could be reduced by one $1 for each dollar of medical expenses in excess of 15 percent of income. In this case, a family with an income of $10,000 and medical expenses of $4,000 would have its taxes reduced by $2,500. A family with income of $40,000 and the same medical expenses would receive no reduction in taxes. Such an approach would have several advantages over a tax deduction.

First, tax benefits would be concentrated on those for whom medical expenses pose the most serious financial burdens.

Second, individuals would be guaranteed that their payments for medical expenses would not exceed some reasonable fraction of income—any expenses above that would be "paid" by the Federal Government.

Third, the Government would no longer be paying a higher share of medical bills for higher income individuals.

A refundable full tax credit on all medical expenses in excess of 15 percent of income would cost less than current tax subsidies for medical and health insurance. Benefits under the tax credit plan would be concentrated much more heavily toward low income individuals.

Under current law, 21 percent of personal income tax benefits for medical expenses go to individuals with incomes of less than $10,000.

Under proposed legislation, 34 percent of benefits would go to such individuals. Under a refundable full tax credit for all medical expenses in excess of 15 percent of income, 70 percent of the tax benefits would go to individuals with incomes below $10,000.

While such a plan would do much to alleviate the financial distress of catastrophic medical expenses, a strong case can be made for shifting from a patchwork system of Medicaid for the poor, Medicare for the elderly, private insurance for many others, and tax subsidies for catastrophic expenses to a new system of comprehensive national health insurance designed to move toward three objectives:

(1) Insuring that everyone has access to essential medical care regardless of income, location, or type of family;

(2) Protecting everyone from medical expenses that are high relative to income; and

(3) Reducing costs and encouraging efficiency in the delivery of medical care. One general type of proposal that seems best adapted to meeting the three criteria at once is a national health insurance plan with income-related benefits.

Under such a plan both deductibles and coinsurance would be related to income so that people would be protected against expenses that were high relative to their income.

To prevent undue financial burdens a ceiling could be placed on the maximum out-of-pocket expenses a family would have to pay.

For example, under the plan, a middle-income family could be responsible for all expenses under 10 percent of income. Above that, the

plan could pay half of all expenses until total expenses exceed 20 percent of family income.

Once total expenses reached 20 percent of income, the insurance plan could pay all expenses. More generous provisions could be designed for lower income families.

To encourage use of preventive services, it might be desirable to have no payment by the lowest income groups. One advantage of such an approach is that a single plan would serve the dual purpose of protecting the poor against normal expenses and protecting higher income people against high expenses, hence, there would be no stigma attached to receiving benefits under the plan. Benefits would depend solely on the relationship between the expense incurred and a family's income, not on arbitrary factors such as where the family happens to live or who is in the family group.

The fact that people would normally be paying part of the expenses themselves could be expected to lessen wasteful use of medical resources and encourage both doctors and their patients to use less, rather than more costly types of care.

Unlike a tax subsidy scheme, a national health insurance plan could incorporate controls on unnecessary utilization, excessive charges by medical care providers, and inferior quality of care as a condition for payment of bills. It could also contain incentives promoting the use of innovative and more efficient forms of organizing and delivering medical care services.

While an adequate financing program is essential in assuring access to medical services and prevening financing burdens arising from large medical bills, such a financing program cannot be relied upon to solve all the problems of the health care system.

Experience with existing financing programs clearly suggests that even with comprehensive national health insurance some groups—especially minority groups and residents of central cities and farms—would get substantially less care than others unless special efforts were made to increase the access of these groups to care.

In 1969, average reimbursement for hospital and physician services per elderly white person was $320 compared with $229 per elderly black person. This discrepancy is explained by the fact that elderly whites use more medical services even though elderly whites enjoy better health than elderly persons of other races.

Since comprehensive financing appears not to eliminate racial disparities, it is urgent that supplementary measures be undertaken on the supply side to improve the physical access of blacks to medical resources—such as increasing the supply of black medical personnel. training of minority residents as paraprofessional personnel to work in community health organizations, subsidies for health care organizations to locate in minority neighborhoods, and improved and expanded hospital outpatient facilities. I would like to add my concern to that of Dr. Cooper about the shortage of scholarships for minority students to enter medical schools and other health professional schools.

In addition to promoting policies designed to overcome nonfinancial barriers to access to medical care, Federal intervention is required to improve the operation of the market for medical services. The most crucial of these are:

(*a*) Supplementary measures to control costs of medical services.

(*b*) Incentives to foster the development of innovative forms of organizing and delivering medical care services.

(*c*) Measures to assure a desirable mix and supply of medical manpower.

Thank you.

Chairman Humphrey. We are very indebted to you for the very splendid oral and prepared statements and all of your material in your prepared statement will be printed in full in the record at this point.

[The prepared statement of Mrs. Davis follows:]

Prepared Statement of Karen Davis [1]

Financial Medical Care Services: The Federal Role

Thank you for the opportunity to testify on the federal role in providing adequate health care to the American people at reasonable cost. The federal government currently plays a major role in financing medical care services through the Medicare and Medicaid programs. In addition, the federal government subsidizes the purchase of health insurance and the payment of medical expenses for most Americans through special tax provisions. Federal payment of medical services, either directly or indirectly through foregone tax revenues, is estimated to amount to $23 billion in 1974.

Since the Administration has proposed several major changes in these programs, I have organized my oral statement around three questions: (1) What deficiencies in financing services for all Americans exist even with current programs? (2) Are the changes in these programs which have been proposed the most effective way of meeting these deficiencies? (3) What problems in the medical care system are unlikely to be solved by even the best financing arrangements?

The case for a major federal role in financing medical services is largely undisputed. While medical care is only one factor contributing to health, it is often a critical factor—sometimes a matter of life and death. Society has come increasingly to the view that adequate medical care is a basic right, neither to be denied nor treated as a charity to those who are poor. Moreover, people have more than altruistic interest in seeing that others get medical care. Communicable diseases are reduced by immunization and treatment, healthier children do better in school, and a healthier work force means a more productive economy.

Without public help many people will be unable to finance needed medical care or will be able to do so only with hardship. Medical bills often come in large unpredictable amounts. Private insurance mitigrates, but does not solve the problem of financing health care. For the poor, even when payments are spread over time and risks shared through insurance, buying adequate health care is an excessive burden. Medical care, especially preventive care, is likely to be postponed. For the middle class, average medical expenses and standard health insurance coverage do not take an impossibly high share of income, but for those afflicted with major health catastrophes, medical expenses can suddenly bring financial distress or even ruin. Most private insurance does not offer adequate protection against such expenses. Even for the half of the population covered by some major medical insurance, limits are frequently placed on expenditures which will be covered and individuals are required to pay a sizable fraction of those expenditures that are covered.

CURRENT FEDERAL PROGRAMS FINANCING MEDICAL CARE SERVICES

Since the mid-1960s the federal government has played a major role in financing individual medical care services through the Medicare and Medicaid programs. In addition to these well-known programs, the federal government subsidizes the purchase of health insurance and the payment of medical expenses through special tax provisions. Under the personal income tax, individuals may deduct one-half of the cost of health insurance premiums plus all medical ex-

[1] The views presented in this statement are those of the author and not necessarily those of the officers, trustees, or other staff members of The Brookings Institution.

penses (including the remaining premium) that exceed three percent of his income. These provisions benefit high income people far more than low income people, because high income people are more likely to itemize deductions and because they face higher tax rates. A thousand dollar deduction is worth $140 to the taxpayer facing a 14 percent tax rate and $700 to a taxpayer in the 70 percent bracket.[2] Moreover, the fact that employer contributions to health insurance for employees are not included as income on the employees' income tax results in loss of revenue to the government. The federal government, therefore, subsidizes the purchase of health insurance both by individuals and by employers on their behalf.

These three programs for financing individual medical care services have met many gaps in private health insurance coverage. Medicare has brought insurance to many elderly people who would otherwise have lost their insurance coverage on retirement. Medicaid has helped the poor, a group with little private health insurance coverage. Only a third of the poor have any private insurance protection compared with 90 percent of families with incomes of $10,000 or more. The tax provisions provide some relief for families with high medical expenses who itemize deductions under the personal income tax.

As shown in Table 1, federal expenditures under both Medicare and Medicaid go primarily to low income groups. This is hardly surprising since Medicaid is explicitly designed to aid the poor and Medicare aids the elderly population which is disproportionately represented at the low end of the income scale.[3] Tax subsidies by contrast give only a little relief to the poor, primarily the working poor with health insurance. Most of the benefit of tax subsidies is concentrated in the middle and upper income groups. If one puts all three programs together, about 45 percent of the total benefits go to people in families with incomes below $5,000. This concentration of benefits on low-income groups, however, is largely attributable to sizable expenditures for low-income old people. Of the $5 billion in benefits for people under 65 in 1970, only 28 percent went to people with family incomes under $5,000, while 40 percent went to individuals with more than $10,000 income. Indirect payment of medical services for middle and upper income families, therefore, substantially exceeds that made on behalf of the non-elderly poor by the federal government.

TABLE 1.—DISTRIBUTION OF BENEFITS UNDER CURRENT PROGRAMS, BY INCOME AND AGE, 1970

	Total Federal benefits	By program			By age	
		Medicare payments	Federal medicaid payments	Federal tax subsidies	Under age 65	Age 65 and over
Total amounts (in millions)	$14,224	$7,494	$2,930	$3,800	$4,994	$9,230
Percentage distribution—Family income	100	100	100	100	100	100
Under $5,000	45	54	67	13	28	54
$5,000 to $9,999	28	26	24	31	32	26
$10,000 to $14,999	16	14	5	26	21	13
$15,000 and above	11	7	4	30	19	7

Sources: Total medicare and medicaid payments are from U.S. Social Security Administration, Office of Research and Statistics, Compendium of "National Health Expenditures Data," DHEW (SSA), 73-11903 (1973), p. 73; the distribution is derived from unpublished estimates of payments by family income. The amount of tax subsidy is from Brigder M. Mitchell and Ronald J. Vogel, "Health and Taxes: An Assessment of the Medical Deduction," unpublished paper, 1973; the distribution is based on data in ibid., p. 34, and Martin S. Feldstein and Elizabeth Allison, "Tax Subsidies of Private Health Insurance: Distribution, Revenue Loss and Effects," in "The Economics of Federal Subsidy Programs," Joint Economic Committee, U.S. Congress (forthcoming).

PROBLEMS IN CURRENT PROGRAMS

Current federal programs help millions of people pay for medical care, but they have three major flaws: (1) they are extremely uneven in coverage and benefits; (2) they provide little protection against catastrophic medical expenses; (3) the tax subsidy program offers large benefits to the rich and little to the poor.

[2] Coverage of out-of-pocket expenses under the personal income tax is equivalent to providing each taxpayer itemizing deductions with an insurance policy which has a deductible equal to 3 percent of the taxpayer's income and a coinsurance rate that is one minus his marginal effective tax rate.

[3] In 1970, 58 percent of elderly individuals were in families with less than $5,000 income; only 18 percent of the elderly have family incomes above $10,000.

Relative to other groups the elderly have been treated generously under federal health financing programs. Medicare provides substantial benefits for hospital and physician care for retired persons covered by social security no matter where they live or what their income. In addition a substantial portion of medical money in some states is spent for medical services to impoverished old people covered by Medicaid.

These programs do not, however, relieve old people of all medical expenses. Indeed, the elderly now pay more for medical care out-of-pocket than before the inception of the Medicare program. Private payments for personal health care of the elderly averaged $309 in fiscal year 1966, before the introduction of Medicare. In fiscal 1972, private payments totaled $404 per capita (including $67 in Medicare premiums). The predominantly poor elderly population, therefore, has not been protected from the ravages of medical care inflation.

High out-of-pocket expenses of the elderly are partly attributable to the fact that Medicare does not protect old people from the expenses of prolonged hospitalization or extremely serious illness. Under the hospital portion of Medicare, after the first 60 days the individual pays $18 per day. After the 90th day, the individual may use a lifetime reserve of 60 hospital days, making a contribution of $36 per day. However, once the individual has been in the hospital for 150 days, the program makes no further payments (or after 90 days if the individual has already used up the lifetime reserve), and the individual is forced to pick up all expenses. Under the physician portion of Medicare, individuals must pay 20 percent of the physician charge even if the charge runs into many thousands of dollars. Other benefits such as private duty nursing care and out-of-hospital drugs are not covered at all. If an elderly individual is sick enough for long enough, he may incur bankrupting out-of-pocket costs.

Medicaid has been plagued from its inception by the federal-state nature of the program, so that low-income individuals in some geographical areas have complete protection against virtually all medical expenses while low-income individuals in other geographical areas have only limited Medicaid benefits.[4] As shown in table 2, 46 percent of poor individuals live in the South, yet only 17 percent of Medicaid payments go to individuals in that area. Three states, New York, Massachusetts, and California, spend 50 percent of all Medicaid funds. In addition to geographical inequities created by the Medicaid program, by tying benefits to eligibility for welfare, many poor individuals without adequate private health insurance coverage receive no coverage from Medicaid—such as the working poor, childless couples, and low-income families with an unemployed father in states which do not provide cash assistance for such families.

TABLE 2.—DISTRIBUTION OF BENEFITS UNDER CURRENT PROGRAMS, BY RESIDENCE, 1970

	Medicare		Medicaid	
	Elderly population	Medicare payments	Poor population	Federal medicaid payments
Total amounts (in millions)	20	$7,494	26	$2,930
Percentage distribution—Residence	100.0	100.0	100.0	100.0
Northeast	25.9	28.6	17.8	39.6
North-central	28.5	27.7	21.9	19.2
South	30.1	25.7	45.7	16.7
West	15.4	18.0	14.6	24.5

Sources: U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, "Health Insurance for the Aged: Monthly Reimbursements per Person by State, 1970," HI-41, 1973, table 1; U.S. Department of Health, Education, and Welfare, National Center for Social Statistics, "Numbers of Recipients and Amounts of Payments under Medicaid and Other Medical Programs Financed from Public Assistance Funds, 1970," NCSSB-4 (CY 70), 1972, table 1.

Existing tax subsidies for health insurance and medical expenses also contain a number of deficiencies. First, they channel large amounts of federal revenues to middle and upper income persons for health insurance premiums—expenses which could be met by most upper income persons without undue financial burden. Of the $3.8 billion in tax subsidies in 1970, $2.5 billion stemmed from tax treat-

[4] See Charles L. Schultze et al., *Setting National Priorities: The 1973 Budget*, Washington, D.C.: Brookings Institution, 1972, pp. 218–220 for a more complete discussion of the medicaid program.

ment of health insurance premiums. Second, tax provisions covering direct medical expenses do not adequately protect individuals from catastrophic expenses. For example, if a family with income of $10,000 incurred $4,000 of medical expenses, its taxes would be reduced by $703. While this is some compensation, it is far from adequate protection against excessive medical bills. Third, the education mechanism is an inequitable method of compensating individuals for financial losses from catastrophic medical expenses. For example, if a family with income of $30,000 incurred the same $4,000 of medical expenses, its taxes would be reduced by $1,176.[5] The federal government "pays" a higher share of the medical expenses of the family whose income is four times as high, and who presumably could better afford the $4,000 expenditure. In short. tax deductions do not meet the needs of either the poor or the middle income class. For the former, they provide little assistance at all. For the latter they help pay for normal medical expenses—which are not a burden—and do little to help pay for catastrophic expenses, which are the real medical problem for middle income families.

PROPOSED CHANGES IN CURRENT PROGRAMS

The Administration's budget for fiscal year 1974 proposes cutbacks in Medicare that will result in the elderly paying a larger share of hospital and physician bills. Coinsurance under the physician portion is to be increased from 20 percent to 25 percent and the deductible increased from $60 to $80. This change will reuslt in substantially higher costs for all Medicare beneficiaries using physicians' services. Individuals incurring physicians' bills of $2,000—as do about 400,000 Medicare beneficiaries every year—under current law would pay $450 of those bills. Under the proposed law, they would pay $560. For those unfortunate enough to incur physician charges of as much as $10,000, the individual's share of the bill would increase from $2,050 under current law to $2,560 under the proposed law.

Under the hospital part of Medicare, present copayments will be replaced by a requirement that all individuals pay 10 percent of the total charges for hospital care for all covered days. Most Medicare beneficiaries with hospital stays of 100 or more days would face somewhat lower charges than under current law and for very long stays the reduction in charges would be quite significant. However, since 99 percent of all Medicare hopsital stays are less than 100 days in length, most Medicare patients would be required to pay higher charges. Under current law, a patient hospitalized for 30 days, for example, would pay only the initial deductible, estimated to be $84 in 1974. Under proposed legislation, if he incurerd average hospital bills he would be required to pay approximately $400.

Day of hospital stay	10	20	30	60	90	150
Percent of stays exceeding this length of stay	50	21	10	2	1	.06
Total patient payments in 1974 under current legislation	$84	$84	$84	$84	$714	$3,234
Average total patient payments in 1974 under proposed legislation	$167	$281	$392	$678	$864	$1,163

The Administration estimates that these changes in the Medicare law will reduce federal expenditures by $500 million in fiscal year 1974, and $1.3 billion in 1975—the first full year covered by the change.

Greater use of coinsurance features in health insurance coverage can have desirable consequences. Coninsurance on hospital charges, for example, encourages patients and physicians to select less expensive hospitals and reduce excessively long hospital stays, and by doing so discourages hospitals from charging exorbitant fees. The proposed changes in cost-sharing under Medicare are particularly inappropriate, however, because: (1) they are not related to income; (2) they contain no ceiling on coinsurance payments; and (3) savings generated by the coinsurance provisions are not used to provide better protection against catastrophic expenses—such as an increase in covered hospital days or coverage of out-of-hospital prescription drugs.

Any discussion of cost-sharing provisions must be in the context of reasonable ability to pay such charges. Few elderly individuals have sufficient incomes to

[5] Since only those expenses in excess of 3 percent of income can be deducted, the higher-income family has lower total medical deductions. However, the higher marginal tax rate faced by the family with $40,000 income results in a greater tax savings. Comparison here is based on a family of four.

pay sizeable coinsurance amounts: only 18 percent of the elderly had family incomes above $10,000 in 1970. In addition, the elderly already pay twice as much out-of-pocket for medical services as other population groups. Under proposed legislation, an elderly couple with one member hospitalized for 30 days and physician bills of $2,000 could expect to pay medical expenses of at least $1,500 (including Medicare premiums, noncovered benefits such as drugs, and normal medical expenses for the other family member). Most would agree that such an out-of-pocket payment is excessive for any family with income below $10,000—or about 82 percent of all elderly individuals.

It might be argued that greater use of coinsurance under Medicare would not cause financial burdens because the Medicaid program could pick up coinsurance amounts for the elderly poor. Experience with the Medicaid program, particularly the wide variation in benefits across geographical areas, gives little hope that the Medicaid program can be relied upon to protect all the elderly poor from excessive bills. Furthermore, many elderly persons who could face serious financial burdens under the proposed changes would not be sufficiently poor to qualify for Medicaid. Only 19 percent of the elderly are currently covered by Medicaid.

In addition to the changes in the Medicare program, the Administration has also proposed eliminating the adult dental benefit in the Medicaid program, resulting in a federal savings of $75 million in 1974. Extension of coverage to clinics not associated with hospitals will offset $20 million of this savings and increases in Medicaid expenditures for the elderly necessitated by changes in the Medicare program will offset another $44 million—resulting in a total savings of $11 million. Although these sums are small in relation to total Medicaid expenditures, they should be viewed in the context of past changes in the Medicaid program. The Department of Health, Education, and Welfare estimates that the poor will receive about $1.3 billion less in Medicaid benefits in 1974 as a result of the Social Security Amendments of 1972. At a time when medical costs are rising, legislative effort should be devoted to remedying the deficiencies of the Medicaid program—such as the low benefits in many states and exclusion from coverage of the working poor, childless couples, and, in some states, low-income families with an unemployed father—rather than continuing to cut back benefits.

Recently, the Administration has proposed changes in the tax provisions affecting health insurance and medical expenses. In testimony before the House Ways and Means Committee on April 30, 1973, Secretary of Treasury Shultz indicated that as part of a personal income tax simplification plan, the Administration proposes elimination of the special treatment of individual health insurance expenses. In its place is a single deduction for all medical expenses, health insurance premiums, and casualty losses; an itemized deduction would be permitted only to the extent that the combined total exceeds a floor equal to 5 percent of the taxpayer's adjusted gross income. No change in tax treatment of employer contributions to health insurance premiums is proposed.[6] While this change has the effect of reducing tax subsidies for medical expenses which go in large part to higher income groups—inequities arising from the greater value of a deduction to higher income individuals would still be present.[7]

A still better alternative would be to replace all existing tax benefits for health insurance and medical expenses with a tax credit for all medical expenses in excess of some percentage of income. For example, taxes could be reduced by one dollar for each dollar of medical expenses in excess of 15 percent of income. In this case, a family with an income of $10,000 and medical expenses of $4,000 would have its taxes reduced by $2,500. A family with income of $40,000 and the same medical expenses would receive no reduction in taxes. Such an approach would have several advantages over a tax deduction. First, tax benefits would be concentrated on those for whom medical expenses pose the most serious financial burdens. Second, individuals would be guaranteed that their payments for medical expenses would not exceed some reasonable fraction of income-any expenses above that would be "paid" by the federal government. Third, the

[6] Department of Treasury, *Proposals for Tax Change*, Washington, D.C.: U.S. Government Printing Office, 1973. Originally, the detailed explanation of tax changes included a provision requiring that employer contributions to health insurance plans be counted as taxable personal income; this provision is marked "deleted" in the report, and presumably is no longer an administration proposal.

[7] Under proposed legislation, a family of four with income of $10,000 and medical expenses of $4,000 would receive a tax reduction of $665, while a family with $40,000 income and the same medical expenses would receive a tax reduction of $840.

government would no longer be paying a higher share of medical bills for higher income individuals.[8]

TABLE 3.—TAX SUBSIDIES FOR MEDICAL EXPENSES UNDER CURRENT AND ALTERNATIVE LAWS, 1974

	Current law	Law 1	Law 2	Law 3	Law 4	Law 5
Total tax subsidy [1] [2] (in millions)	$2,625	$860	$2,227	$3,399	$789	$1,476
	Percentage distribution					
Adjusted gross income class	100.0	100.0	100.0	100.0	100.0	100.0
Under $5,000	2.0	4.1	27.4	23.3	9.5	7.2
$5,000 to $9,999	18.7	29.7	43.3	43.2	40.4	39.3
$10,000 to $14,999	21.6	19.4	9.7	13.1	14.2	20.5
$15,000 and over	57.8	47.0	19.4	20.3	36.0	33.0

[1] None of the plans include $3,000,000,000 tax subsidy in 1974 attributable to exclusion of employer contributions to health insurance plans from taxable personal income.

[2] Estimates are based on individuals currently itemizing medical deductions. Many low-income individuals who do not currently itemize deductions would be eligible for benefits under a tax credit plan. Tax subsidies shown, therefore, are underestimated—particularly for laws 2 and 3 which would refund any excess of the credit over total tax liability. The estimates do not consider any changes in prices, use of medical services, or health insurance coverage induced by the credit.

NOTES

Law 1: Itemized deduction of all health insurance and medical expenses in excess of 5 percent of income (administration proposal omitting casualty losses).
Law 2: Full tax credit for all health insurance and medical expenses in excess of 15 percent of income, refundable.
Law 3: Full tax credit for all health insurance and medical expenses in excess of 10 percent of income, refundable.
Law 4: Full tax credit for all health insurance and medical expenses in excess of 15 percent of income, nonrefundable.
Law 5: Full tax credit for all health insurance and medical expenses in excess of 10 percent of income, nonrefundable.

Source: Estimates derived from the 1970 file of individual income tax returns with data projected to calendar year 1974 levels.

Table 3 illustrates the costs and distribution of benefits by income class in 1974 under existing legislation, legislation proposed by the Administration, and several alternative tax credit schemes. The proposed legislation would reduce tax subsidies arising from personal income tax deductions from $2.6 billion in 1974 to $860 million.[9] A refundable full tax credit on all medical expenses in excess of 15 percent of income would result in a tax subsidy of $2.2 billion—if only those individuals who currently itemize medical expenses were to take advantage of the tax credit. However, many low-income individuals who do not currently itemize deductions would be eligible for benefits under a tax credit plan so that the costs are underestimated. The estimates also do not consider any changes in prices, use of medical services, or health insurance coverage which would be induced by the credit. Final cost of the scheme, therefore, could substantially exceed $2.2 billion. Benefits under the tax credit plan would be concentrated much more heavily toward low income individuals. Under current law, 21 percent of personal income tax benefits for medical expenses go to individuals with incomes of less than $10,000.[10] Under proposed legislation, 34 percent of benefits would go to such individuals. Under a refundable full tax credit for

[8] The major disadvantage of such a tax credit plan is the absence of any control on expenditures above 15 percent of income. The range over which individuals have some incentive to contain costs could be extended by a tax credit which reduces taxes by 50 cents for each dollar of expenditures between 10 and 20 percent of income, and dollar for dollar for all expenditures for all expenditures over 20 percent of income. Another possibility is a tax credit which reduces taxes 80 cents for each dollar of expenditure over 12 percent of income. This maintains some incentive for the individual to contain costs over the entire expenditure range, but leaves the individual vulnerable to excessively high costs.

[9] Total tax subsidy, including $3 billion in 1974 attributable to exclusion of employers' contributions to health insurance plans from taxable personal income, would be $5.6 billion under current legislation and $3.9 billion under proposed legislation.

[10] This differs from the 44 percent given in table 1 because it applies only to individual health insurance premiums and medical expenses deducted from the personal income tax. Tax subsidies of employer contributions to health insurance premiums, which are excluded here, are concentrated more heavily on low- and middle-income workers.

all medical expenses in excess of 15 percent of income, 70 percent of the tax benefits would go to individuals with incomes below $10,000.

While such a plan would do much to alleviate the financial distress of catastrophic medical expenses, a strong case can be made for shifting from a patchwork system of Medicaid for the poor, Medicare for the elderly, private insurance for many others, and tax subsidies for catastrophic expenses to a new system of comprehensive national health insurance designed to move toward three objectives: (1) ensuring that everyone has access to essential medical care regardless of income, location, or type of family; (2) protecting everyone from medical expenses that are high relative to income; and (3) reducing costs and encouraging efficiency in the delivery of medical care. One general type of proposal that seems best adapted to meeting the three criteria at once is a national health insurance plan with income related benefits. Under such a plan both deductibles and coinsurance would be related to income so that people would be protected against expenses that were high relative to their income. To prevent undue financial burdens a ceiling could be placed on the maximum out-of-pocket expenses a family would have to pay. For example, under the plan, a middle-income family could be responsible for all expenses under 10 percent of income. Above that, the plan could pay half of all expenses until total expenses exceed 20 percent of family income. Once total expenses reached 20 percent of income, the insurance plan could pay all expenses. More generous provisions could be designed for lower income families. To encourage use of preventive services, it might be desirable to have no payment by the lowest income groups. One advantage of such an approach is that a single plan would serve the dual purpose of protecting the poor against normal expenses and protecting higher income people against high expenses, hence, there would be no stigma attached to receiving benefits under the plan. Benefits would depend solely on the relationship between the expense incurred and a family's income, not on arbitrary factors such as where the family happens to live or who is in the family group. The fact that people would normally be paying part of the expenses themselves could be expected to lessen wasteful use of medical resources and encourage both doctors and their patients to use less, rather than more costly types of care. Unlike a tax subsidy scheme, these automatic incentives could be supplemented with controls on unnecessary utilization, excessive charges by medical care providers, and inferior quality of care. It could also contain incentives promoting the use of innovative and more efficient forms of organizing and delivering medical care services.

PROBLEMS NOT SOLVED BY FINANCING

While adequate financing program is essential in assuring access to medical services and preventing financing burdens arising from large medical bills, such a financing program cannot be relied upon to solve all the problems of the health care system. Experience with existing financing programs clearly suggests that even with comprehensive national health insurance some groups—especially minority groups and residents of central cities and farms—would get substantially less care than others unless special efforts were made to increase the access of these groups to care.

Under Medicare, for example, uniform benefits are available to all participants, but average expenditures are substantially less for blacks than whites. Although 8.6 percent of the elderly population belongs to a black or other non-white race, they receive only 5.9 percent of the payments made by the program. In 1969, average reimbursement for hospital and physician services per elderly white person was $320 compared with $229 per elderly black person. Most of this discrepancy is explained by the fact that elderly whites use more medical services even though elderly whites enjoy better health than elderly persons of other races.[11]

[11] Indeed the poor health of blacks, reflected in their high mortality rates, reduces the chance that blacks will live long enough to benefit from medicare at all. Present life expectancies imply that only 56 percent of black babies will live to age 65, compared with 74 percent of white babies.

TABLE 4.—USE OF MEDICAL SERVICES BY THE ELDERLY, BY RACE, 1968-69

Type of service	Whites	All other races
Hospital care:[1]		
Discharges per 1,000 medicare enrollees	312	237
Hospital days per 1,000 medicare enrollees	4, 150	3, 491
Hospital charges per day	$65	$60
Medicare payments per elderly person	$215	$150
Physican care:[2]		
Annual visits per person	6. 2	5. 1
Percent of visits in hospital clinic	5. 4	15. 3
Medicare payments per elderly person[3]	$105	$79
Health Status:[2]		
Restricted activity days per person per year	33. 1	47. 6
Bed disability days per person per year	13. 1	20. 5
Percent with limitations due to chronic conditions	41. 6	51. 4
Percent unable to carry on major activity	15. 1	25. 0

[1] Current medicare survey report, hospital insurance sample, inpatient hospital utilization, 1966-69, CMS-2S, Office of Research and Statistics, Social Security Administration, March 1973.
[2] "Age Patterns in Medical Care, Illness, and Disability, United States, 1968-69," Series 10, No. 70, National Center for for Health Statistics, U.S. Department of Health, Education, and Welfare, April 1972.
[3] Calculated from 1970 data supplied by the Social Security Administration.

Elderly whites have fewer restricted activity days, fewer bed disability days, and fewer suffer from chronic health conditions. In spite of the better health status of elderly whites, whites are admitted to the hospital more frequently, use more days of hospital care, and visit the physician more frequently. Since comprehensive financing appears not to eliminate racial disparities, it is urgent that supplementary measures be undertaken on the supply side to improve the physicial access of blacks to medical resources—such as increasing the supply of black medical personnel, greater placement of black physicians on hospital staffs, training of minority residents as paraprofessional personnel to work in community health organizations, subsidies for health care organizations to locate in minority neighborhoods, and improved and expanded hospital outpatient facilities.

In addition to barriers to medical care for blacks and other non-white groups, residence is also an important determinant of use of medical care services. Rural residents lag well behind residents of urban areas in use of medical services—even though rural residents are more likely to have some limitation of activity. Special efforts, perhaps through improved medical transportation systems, will be required to improve access of rural residents to high quality care.

In addition to promoting policies designed to overcome non-financial barriers to access to medical care, federal intervention is required to improve the operation of the market for medical services. The most crucial of these are: Supplementary measures to control costs of medical services; incentives to foster the development of innovative forms of organizing and deliverying medical care services; and measures to assure a desirable mix and supply of medical manpower.

Chairman HUMPHREY. I will come back for some further questions, but I want our next witness, who is Mr. Alfred Neal, who is president of the Committee for Economic Development, and we look forward to your testimony; and by the way, I want to again compliment CED for outlining an overall strategy for health care. It is a great contribution on your thinking.

Go ahead, Mr. Neal.

STATEMENT OF ALFRED C. NEAL, PRESIDENT, COMMITTEE FOR ECONOMIC DEVELOPMENT, ACCOMPANIED BY JEROME POLLACK, PROFESSOR OF ECONOMICS OF MEDICAL CARE, HARVARD MEDICAL SCHOOL

Mr. NEAL. Thank you, Mr. Chairman.

I am Alfred C. Neal, president of the Committee for Economic Development, which is an organization of 200 leading businessmen and university presidents who study major economic and social issues, and

formulate recommendations on Government and business policy that deal with these issues.

I am appearing today as a substitute for Philip M. Klutznick, chairman of the CED Research and Policy Committee, who headed our study on health care.

With me is Mr. Jerome Pollack, who was the project director. He was the organizer of the Harvard Community Health Plan.

Because we arrived at our conclusions on this study before the budget was presented, it will only be possible from the study itself to refer to a few of the consequences of budget cuts, but Mr. Pollack is a living and up-to-date authority in his area and will be able to extend the discussion as it applies to the budget reductions.

We do very much appreciate the opportunity to be here.

I shall, as the others have done, make a very short oral statement drawing essentially from the prepared statement, and should like to submit the whole of this study,[1] if it is agreeable, as an exhibit.

Chairman HUMPHREY. Yes, I would very much appreciate it. If you could leave an extra copy or two, I should like to share it with some of our colleagues.

Mr. NEAL. Yes, sir. Our study in some respects grew out of a study of Governor Rockefeller's so-called Steering Committee on Social Problems, on which I and others responsible for the CED served.

A key finding of that study and of our own study was that the way in which health care services are delivered today—that is to say, the organization of the delivery system—virtually assures the Nation of a continuing spiral of inflation because of the lack of incentives for control of costs.

I hope you don't mind my painting it, sir, with a very broad brush, but that conclusion was unexceptional in its broadness, anyway.

Chairman HUMPHREY. Go ahead, sir.

Mr. NEAL. Specifically, payment by reimbursement of cost, which is the basis for most of the repayment plans, is in our view a primary source of continuing inflation.

The Steering Committee emphasized in its study, and we did also, that it would be a disservice to the Nation to set up a national health insurance system without improving the way in which health services are delivered and how providers are paid.

For that reason, I shall say most of what I have to say orally, at least, about the delivery system.

As I mentioned, we were greatly aided in our work by Mr. Pollack and by a number of outstanding professionals in the field.

We, of course, are laymen and have no substantive knowledge of the medical practice itself.

The problem as we saw it was not simply to keep down costs, but also to assure access to health care as a right to all.

We believe that any serious effort to improve health care must embrace, (1) the restructuring and redeployment of the health care delivery system with an effective control and planning mechanism, and (2) an enlarged insurance system to insure universal coverage.

On the matter of inflation, Mr. Chairman, we subscribe exactly to

[1] The study may be found in the subcommittee files.

the numbers which you cited in your opening statement, and so I shall spare you going over those again.

I think I could add one small item, however, that in the period since 1950, nearly one-half of the increase in costs has been attributable to price rises rather than to greater utilization of services and introduction of new techniques.

The rate of inflation in the cost of medical services since 1960 has averaged well over half again as much as that of the consumer price index generally.

To stem this massive inflationary tide, we recommended in the middle of 1972, that the Government maintain its wage and price controls in the health care field, and we are pleased to note that under the so-called phase III this has been done.

We further recommend that if a national health insurance system is instituted, some or all of those wage and price controls should be maintained during the phasing in.

As to the problem of the consumer and why the market does not take care of him, there are disabilities not to be found in the ordinary shopping that the consumer does for other goods and services. He cannot shop around, or does not shop around. He does less about medical service than almost any other service he pays for.

Consumer ignorance, monopolistic conditions of supply, and cost plus pricing effectively prevent the market from protecting the consumer from high costs.

I make this statement because so many people argue that the market should be left to allocate this essential service and the conditions that I cited are not the conditions under which free markets operate, but are in fact violations of the conditions necessary.

To correct these conditions, the doctor who is the most expensive element involved, must be employed only in the tasks calling for his very high skills. Lesser tasks can be performed by paraprofessionals and other lower paid health personnel.

These imperatives call for group practice and other forms of organization.

This road to efficiency has been well traveled by business and by other professions, and if we are offering anything in this area, Mr. Chairman, it is that we have people who know how to organize things and get costs down.

This is a finding of their experience. Such organization as the Kaiser Foundation health plans have shown that the way to remedy the deficiencies in delivery and cost is through the health maintenance back to organization.

We also found there were grave shortcomings in the way in which hospitals are organized.

Fewer hospital beds would be needed if facilities were adequate for ambulatory care.

Most studies of patients show that some people in hospitals either do not need to be there or stay too long. Hospitalization is used far less in better organized systems, where the incentives work to treat patients on an ambulatory basis when this is appropriate, rather than as inpatients. The excess costs which these inefficiencies create for the consumer are obvious.

The administration's decision to terminate those segments of the Hill-Burton program involving the construction and modernization of bed facilities therefore seems well justified.

We are concerned, however, by the fact that Hill-Burton funding for ambulatory and outpatient care facilities—which represents about one quarter of the total program—is also being terminated although the development of such facilities can lead to significant savings in the long run.

Basic to the establishment of a national health care system and reform of the delivery system, therefore, is a greatly accelerated development of community-based ambulatory- and primary-care centers, and organization that assume responsibility for providing comprehensive and continuous care.

The CED report stresses that until doctors, hospitals, and other providers of health care—

> Work within a system which requires them to respond to effective planning that meets national needs and to become involved in the financial consequences of their decisions, costs cannot be controlled and the system cannot be rationalized.

We strongly recommend therefore that to the maximum extent possible, providers of care should be paid on the basis of fees and charges fixed in advance and related to a budget that reflects efficient organization and administration.

Ideally, financing of health care services should be based on prepayment of one annual fee for a family's essential medical needs. The concept of the health maintenance organization represents an efficient way of delivering care under such a payment system. The payment system, in turn, will provide a strong motive for efficient organization and delivery of services.

We also called for the repeal of restrictive State laws which limit the right to organize group practices, to provide comprehensive care, and to establish prepayment plans—all of which would result in better health care at lower cost.

Archaic legislation and regulation have impeded the development of new comprehensive delivery systems. We endorse efforts by the Federal Government to secure adoption of model State laws to facilitate the formation and operation of such organizations and urge that the States adopt legislation supportive of HMO's.

We recommend that Federal support for State health programs be predicated on the elimination of restrictive legislation impeding improvement in the organization of health care.

One of our key recommendations, therefore, is the establishment of regional health service agencies throughout the Nation with strong planning powers over facilities and resources. These planning agencies would determine the need for new health care institutions in each region and would have significant power over the expenditure of Federal funds.

The agencies would aid in the establishment of HMO's and would be responsible for supervising the quality of service. Under our plan, the regional health service agencies would also have effective supervision over pricing and quality arrangements in all HMO's.

We do not have such regional agencies now, although a start has been made.

Our committee made a strong commitment to the principle of universal coverage with the ultimate objective of a high level of benefits for all. However, because of the inadequacies of the delivery system, we insisted that the new health insurance plan should at first cover only basic needs and that benefits should be phased upward only as appropriate changes take place in the organization of the health care system.

We estimate that our recommendations would add something less than $5 million to the Nation's health expenditures over present anticipated costs and would reach this level only after the entire set of basic benefits has been phased in.

We adopted this because somewhere between 80 and 90 percent of the people now have some form of health or medical insurance, so that filling the gap seemed to be the easiest way and most efficient way of getting 100 percent coverage of the employment.

For the aged and disabled we simply recommended that medicare be continued.

For the third category, which Mrs. Davis has talked about eloquently, we would extend insurance coverage on an income-related basis to the more than 20 million people, mostly poor, nonwhite, unemployed and self-employed, who now have no medical coverage.

The Federal Government would finance the costs for the poor. We had in mind a trusteeship arrangement under which people who were entitled to coverage but did not have it would be sought out and they would be informed of their rights; and if they were poor or if they were very low-income, the Federal Government would pay all or part of the cost of the insurance on a sliding scale basis.

Now, Mr. Chairman, I thank you for this time, and Mr. Pollack would be prepared to refer to some of the budget cuts and what they might do toward the movement of the system in the direction that we have indicated would be desirable.

Chairman HUMPHREY. Very good. Thank you very much, Mr. Neal.

[The prepared statement of Mr. Neal follows:]

PREPARED STATEMENT OF ALFRED C. NEAL

HEALTH-CARE COSTS

My name is Alfred C. Neal. I am president of the Committee for Economic Development, which is an organization of 200 leading businessmen and university presidents who study major economic and social issues and formulate recommendations on government and business policy. I am appearing today as a substitute for Philip M. Klutznick, chairman of the CED Research and Policy Committee, who headed our study on health care.

We greatly appreciate the invitation to appear before your Committee. Our concern with the health-care system stems from the involvement of a number of CED trustees in the Steering Committee on Social Problems established by New York Governor Nelson A. Rockefeller. Under the leadership of the late Joseph C. Wilson, chairman of Xerox Corporation and a trustee of CED, the Governor's Steering Committee undertook a national study of health and hospital services and costs. I was privileged to serve on that Committee, which issued its report in June 1971.

A key finding of the Steering Committee was that the way in which health-care services are delivered today—the organization of the delivery system—virtually assures the nation of a continuing spiral of inflation because of the lack of incentives for control of costs. Moreover, the misallocation of resources

in the health-care system has produced inadequate care for many people in our society.

The Governor's Steering Committee underscored the important role that the federal government can play in bringing about reform of the health-care system that will result in less costly service. It is a theme which the CED report develops in greater detail. The Steering Committee said that "any new public funds should be used as a lever for change in the delivery system, and that such funds should contain enough incentives to produce voluntary movement toward efficient, effective and more economical health-care systems." Thus the Steering Committee emphasized that it would be a disservice to the nation to set up a national health insurance system without improving the way in which health services are delivered.

The Committee for Economic Development, whose trustees constituted almost half of the Governor's Steering Committee, built upon the foundation of the Steering Committee report. Under Mr. Wilson's chairmanship we undertook a more detailed study on ways of reforming the delivery and financing of health-care services and particularly of ways to make financing contribute to reform of the system. After Mr. Wilson's sudden and untimely death in late 1971, we were able to prevail upon Philip M. Kutznick to serve as acting chairman of the health-care panel.

We were aware of the dangers in trying to make essentially lay judgments in a highly complex professional field. Nevertheless, as Mr. Wilson had put it, "health care, as an industry, is not unlike many other American industries which are equally far-flung, extraordinarily complex, and yet are susceptible to rational managerial evaluations." It was our feeling that the business community could make an important contribution by bringing the experience of management to bear on an extraordinarily complex and disorganized system.

We were greatly aided in our work by a number of outstanding professionals in the field, including Dr. Jerome Pollack, Professor of Economics of Medical Care at Harvard Medical School, who served as project director for the CED study. We issued our report[1] in April 1973, and I am attaching a copy as an exhibit. The names of those who are responsible for the report are listed on pages 5 and 6.

After an intensive investigation of the delivery and financing of health care, we concluded that even if vastly greater resources are poured into the health-care system, the goal of providing adequate health care for all will continue to elude the nation unless the delivery of health-care services is substantially restructured. We therefore set forth a number of recommendations, which I shall discuss later, to improve the organization of the health-care system. It is this group of recommendations which CED believes holds the greatest promise for keeping down the cost of health care.

At the same time, we had to come to grips with a separate but related problem—the need to provide adequate health care for *all* Americans. The problem as we saw it was not simply to keep down costs but also to assure access to health care as a right to all. The central question we faced was how to convert this right into reality—how to convert an aspiration into skills, services, facilities, and systems available to the people.

In the past, the national mode of response has been to deal separately with each shortcoming of the system in a succession of crises—in facilities, manpower, financing, or social policy. We believe that this is no longer tenable and that a serious effort to improve health care must embrace (1) the restructuring and redeployment of the health-care delivery system, with an effective control and planning mechanism and (2) an enlarged insurance system to assure universal coverage. Most important, a coordinated approach to these two essential components of any national health-care system is essential in order to avoid the danger of inflated health costs that do not produce increased services.

INFLATION IN HEALTH COSTS

The scope of the inflationary problem is well known. The United States devotes a greater share of gross national product to health care than any other nation. The amount of money spent should provide better care for all our people. While it is true that U.S. health services have broadened in scope, and are used with greater frequency and intensiveness, costs have risen beyond the capability of

[1] The report may be found in the subcommittee files.

many people and the local levels of government. Total national health expenditures climbed from $12 billion in 1950 to $83 billion in 1972, or from 4.6 percent to 7.6 percent of Gross National Product. By far the largest element in the increase in expenditures for personal health since 1950—nearly one-half—is attributed to price rises rather than to greater utilization of services and the introduction of new techniques. Largely as a result of inflation, from 1965 to 1972 alone the nation's health-care expenditures rose from $39 billion to $83 billion. The rate of inflation in the cost of medical services since 1960 has averaged well over half again as much as that of consumer prices generally, and has even exceeded the rate of inflation in the cost of housing.

To stem this massive inflationary tide, CED recommended in July 1972 that the government maintain its wage and price controls in the health-care field. We were pleased to note that this course was followed by the Administration in Phase 3. Wage and price controls should be maintained, moreover, during the inauguration of any national health-insurance program in order to avoid runaway costs during the transitional period. Although market influences, of course, are generally preferable to controls, the market has been shown to work inadequately in the health industry, which is inherently monopolistic. Controls will be needed, therefore, until major structural changes have been accomplished.

THE INSECURE ROLE OF THE CONSUMER

The burden of securing adequate health care today rests almost exclusively with the patient. More often than not, he must find his own way among the various types and levels of service, with only partial help from the provider. In the majority of cases, no one in the medical profession takes responsibility for determining the appropriate level of total care needed and for seeing that such care (but no more) is supplied. Not only does this fragmented "nonsystem" lead to great variations in the quality of care rendered, but it also fails to deliver the comprehensive and preventive care now desired.

A patient may choose a doctor because of the nature of his illness at one time or a specialist of the wrong type because of a mistake in early diagnosis; he may stay with this physician in order to avoid the inconvenience and uncertainty of starting over again with another. Often the patient's resources are too limited to permit him to search for another physician even if he wanted to do so, or he may regard it as unseemly and indicative of a lack of confidence in the doctor on whose goodwill he depends. Moreover, the prevalence of one-man medical firms often impedes the free flow of patients from one practitioner to another; such firms run some risk of losing the referred patient to the consultation or the hospital.

Although medical care is only one factor contributing to health, it can be literally a matter of life and death. Self-denial because of low income is not the same in this situation as in rationing one's income when purchasing cars, clothes, or television sets. Medical costs can claim an excessive share of a family's income, even for middle-income people, who usually have insurance. The position of the consumer in the health-care marketplace is indeed an insecure and limited one. In purchasing other goods and services the consumer can police the market by shopping around, but this applies far less to medical services. The average consumer knows less about medical service than almost any other service he pays for.

DEFECTS IN THE PRESENT SYSTEM

In the view of the CED committee, the single doctor in private practice was suited to a time when medical needs could usually be met by the treatment of a single physician but is unsuited to the growing incidence of chronic illness, the trend toward specialization, and toward preventive medicine. The doctor, as the most expensive element involved, must be employed only in tasks calling for his skills. Lesser tasks can be performed by a paraprofessional and other lower paid health personnel. These imperatives call for group practice and other forms of organization. This road to efficiency has been well travelled by business and by other professions.

The present health structure has resulted in a mixture of technical virtuosity among specialists, on the one hand, and inadequacies in the development of minimum essential care, on the other. People generally experience difficulties in securing adequate primary care. Such organizations as the Kaiser Foundation Health Plans have shown the way to remedy this deficiency at reasonable cost.

Although we recognize that the United States possesses some of the finest hospitals and medical centers in the world, we found severe shortcomings also

in the way in which hospitals are organized and managed. In recent years, unnecessary facilities were created nationwide while the existing resources of hospitals were not used effectively. Fewer hospital beds would be needed if facilities were adequate for ambulatory care, self-care, and outpatient treatment.

Most studies of patients show that some people in hospitals either do not need to be there or stay too long. Hospitalization is used far less in better organized systems, where the incentives work to treat patients on an ambulatory basis when this is appropriate rather than as inpatients. The excess costs which these inefficiences create for the consumer is obvious.

The Administration's decision to terminate those segments of the Hill-Burton program involving the construction and modernization of bed facilities therefore seems wll justified. We are concerned, however, by the fact that Hill-Burton funding for ambulatory and outpatient care facilities—which represents about one-quarter of the total program—is also being terminated although the development of such facilities lead to significant savings in the long run.

Basic to the establishment of a national health-care system and reform of the delivery system, therefore, is a greatly accelerated development of community-based ambulatory- and primary-care centers, and organizations that assume responsibility for providing comprehensive and continuous care.

INCENTIVES FOR COST CONTROL: THE HMO

The CED report stresses that until doctors, hospitals, and other providers of health care "work within a system which requires them to respond to effective planning that meets national needs and to become involved in the financial consequences of their decisions, costs cannot be controlled and the system cannot be rationalized." We strongly recommended therefore that to the maximum extent possible, providers of care should be paid on the basis of fees and charges fixed in advance and related to a budget that reflects efficient organization and administration. Ideally, financing of health-care services should be based on prepayment of one annual fee for a family's essential medical needs. The concept of the health maintenance organization represents an efficient way of delivering care under such a payment system. The payment system, in turn, will provide a strong motive for efficient organization and delivery of services.

Although emphasizing preventive care, the HMO provides relatively complete and continuous care for its subscribing clientele. Among the many accomplishments of existing health maintenance organizations are striking reductions in the utilization of inpatient care, as well as improved use of manpower and more complete care at an economical cost to subscribers. The impressive nature of these achievements underlies the growing awareness that the development of health maintenance organizations on a much larger scale would be one of the most effective ways possible to fight the escalation of health-care costs.

Comprehensive prepaid plans have brought competition into health services. We envision these new organizations as operating side by side and competing with conventional practice with the intent of improving the operations of both systems.

Although group-practice prepayment has inspired and stimulated the HMO, it constitutes only one such kind of organization. In order to broaden the base for development and to stimulate innovation in organizational design, diverse sponsorship should be encouraged and is being undertaken, including sponsorship by hospitals, medical groups, foundations for medical care, businesses, consumer and community groups, labor unions, insurance companies, Blue Cross-Blue Shield plans, and academic institutions. There should be room for both profit and nonprofit health-care plans sponsored by all type of organizations that can qualify in terms of capability and responsibility.

In our report we made clear, however, that the potentials of the HMO will not be achieved easily or immediately. There are formidable managerial, financial, and often legal hurdles to overcome in establishing a successful HMO. Nor should prompt public acceptance of this relatively new and unknown form of health-care delivery be expected.

We also called for the repeal of restrictive laws which in some areas limit the right to organize group practices, to provide comprehensive care, and to establish prepayment plans—all of which would result in better health care at lower cost. Archaic legislation and regulation have impeded the development of new comprehensive delivery systems. We endorse efforts by the federal government to secure adoption of model state laws to facilitate the formation and operation of such organizations and urge that the states adopt legislation supportive of

HMOs. We recommend that federal support for state health programs be predicated on the elimination of restrictive legislation impeding improvement in the organization of health care.

PLANNING AND USE OF RESOURCES

In the course of our study, we became convinced that faulty allocation of resources is a major cause of inadequacies in U.S. health services that result today in poor or substandard care for large segments of the population. While manpower, facilities, and services are lacking in some areas, they are in excess in others. The maldistribution is functional as well as geographical, causing most notably the nearly nationwide inadequacy in primary care while medical specialities often exceed requirements. No adequate effort has been made at overall planning. What confronts the United States is an essential industry—the nation's third largest in terms of people employed—that delivers vitally important services at a level far below its potential capability.

One of our key recommendations, therefore, is the establishment of Regional Health Service Agencies throughout the nation with strong planning powers over facilities and resources. These planning agencies would determine the need for new health-care institutions in each region and would have significant power over the expenditure of federal funds.

The agencies would aid in the establishment of HMOs and would be responsible for supervising the quality of service. Under our plan, the Regional Health Service Agencies would also have effective supervision over pricing and quality arrangements in all HMOs. We are convinced, however, that the planning agencies must not be controlled by those who are the providers of health care and recommended that at least a majority of each board consist of public members.

To provide for the efficient training and use of medical personnel, we recommended the adoption of a national health manpower policy and called for systematic central planning by the office of the Secretary of Health, Education and Welfare to guide the formulation of health training programs. Such programs, the Committee said, should focus on the development of more primary—care physicians and the training of doctors' assistants and other new categories of health personnel. They should also aim at reducing the enormous disparities that have developed in the geographical distribution of medical services, with the six most affluent states averaging twice as many doctors per capital as the six poorest states.

HEALTH-CARE COSTS AND THE FEDERAL GOVERNMENT

It is impossible to emphasize enough the magnitude of the contribution the federal government could make towards ending the spiral of health-care costs by encouraging reform of the delivery system along the broad outlines set forth above. The experience of the Kaiser Foundation Health Plans on the West Coast, which serve over two million people, and other prepaid plans is an indication of the significant reductions in cost and improvements in care that can accrue to the consumer through the use of effective management techniques in the delivery of health care.

We are therefore concerned that while some of the new budgetary proposals in the area of health care would contribute to increased efficiency, others are likely to hinder needed improvements. Thus, projected outlays for improving the organization and delivery of health services, for training paramedical personnel, for building ambulatory health facilities, and for operating local mental health clinics are diminishing. We are concerned not only that social needs be satisfied. We are concerned that absence of reform of delivery systems in areas where uncontrolled federal expenditures are growing very rapidly will, in the not very long run, turn out to be a false saving.

A NATIONAL HEALTH INSURANCE PROGRAM

I have concentrated on the need for reforms in the delivery system to curb the spiraling costs in health care. As I mentioned before, however, our committee was also concerned with the need to assure access to adequate health care for all Americans. In our view, there can be no question that universal health coverage should rank high among our national goals.

The national health insurance plan we proposed would provide a basic level of medical protection for everyone through a three-part system. Employers would

be required to provide health insurance coverage for all employees and their dependents, and Medicare would be continued for the aged and disabled. A third category would extend insurance coverage on an income-related basis to over 20 million people—mostly poor, nonwhite, unemployed, and self-employed—who now have no medical coverage. The federal government would finance the costs for the poor.

Our Committee made a strong commitment to the principle of universal coverage with the ultimate objective of a high level of benefits for all. However, because of the inadequacies of the delivery system, we insisted that the new health insurance plan should at first cover only basic needs and that benefits should be phased upward only as appropriate changes take place in the organization of the health-care system. In the Committee's view, the high quality of the medical professions in the United States and the substantial resources devoted to health care are an indication that the goal of adequate health care for all is within reach. But remembering the inflationary surge after Medicare, we felt that making more money available without improving the delivery of health-care services would merely serve to increase costs without producing better care.

In making our commitment to universal coverage, we were greatly encouraged by the strengths and resources of the present health-care system and were determined to build upon them rather than starting over again with a different system. We were impressed by the firm base that already exists for a national health insurance system through the substantial coverage now provided by both private and public insurance plans, including the massive employer-based plans which provide coverage to over 150 million people.

Under the employment based coverage, employers would be required to provide health insurance coverage for all employees, with costs typically shared between employers and employees. The Committee recognized, however, that this requirement could pose some hardships for small or marginal business. We therefore recommended that a specified ceiling such as a percentage of wages be placed on contributions of both employers and employees. Where costs exceed this ceiling, we suggested a sharing of costs through an insurance pooling mechanism.

Under the third category a fundamental change recommended in our report is the establishment of "community trusteeships," which would administer the funding of health insurance and the organization of care for those not covered through an employment-based plan or Medicare—the poor, unemployed, self-employed, or part-time workers. Individuals insured under community trusteeships would contribute to the plan on a sliding scale, based on income, family size, and employment status, with the federal government paying the rest of the cost. Payments would not be required for those whose income is below the national poverty level, and Medicaid would be abolished.

The national health insurance plan which we recommended would provide continuous coverage for all, without interruption for any cause. Treatment would not be delayed for determination of liability for payment, and care would not be foregone or deferred because of inability to pay.

We estimate that our recommendations would add something less than $5 billion to the nation's health expenditures over present anticipated costs and would reach this level only after the entire set of basic benefits has been phased in. For the longer run, the additional costs implied by our financing recommendations should be offset at least in part by the better utilization of resources and cost reductions resulting from basic management improvements.

Shortly after enacting Medicare, Congress reaffirmed its conviction that "fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person." In our report we have recommended a long step towards this goal. The world's weathiest nation should not aspire to less than adequate health care for all its people.

TELEGRAM FROM MARION B. FOLSOM TO THE NEW YORK CONGRESSIONAL DELEGATION—APRIL 13, 1973

I suggest you study the policy statement issued yesterday (April 12, 1973) by the Committee for Economic Development entitled "building a national health-care system." I was active on the committee and favor the proposal. I strongly urge you to endorse by public statement the general principles outlined in this statement. I would go one step further and recommend that the next statutory increase in social security taxes be used to finance the increased revenue requirement for health insurance and that the payroll taxes be reduced for those in the low income group. This deficit would need to be financed by general revenue.

Also, as you know, the health people in the Rochester area are greatly disturbed over the drastic reductions in the health program proposed by the administration. The Rochester area has received meaningful grants from the Department of HEW and the previous administrations over the past years.

These grants have been matched by dollars from local sources and have been in the forefront of new developments in health services. This sudden and sharp reduction will greatly affect the health care of the area. It will set us back in the areas where we have begun to make real progress. I strongly urge that a more selective basis be used to bring about reductions. Savings may be made by postponing the Hill-Burton program and manpower and other long-range programs so that the more effective program can be continued.

The Rochester experience is a clear demonstration of the objective of President Nixon that federal funds be used to encourage the private sector to marshall its resources.

Chairman HUMPHREY. We have a few questions here, and then as may have been indicated, I am sure, Mrs. Davis, you might have some observations on the CED proposal, because I noticed that your testimony was concerned about some of the inequities in the present system and some of the CED proposals recommend an extension of the present system, even though of course there are substantial alterations, particularly for those that have no health insurance coverage at all.

One observation I would make is that really we have sickness insurance more than health insurance. You have to get sick before you get any benefits.

I also have been of the opinion that we ought to have some kind of a health program that kept you well, that was designed primarily to seek out any health problems prior to the time that they became sufficiently acute as to demand medical or hospital attention.

Most every health insurance program that I hear of, Government programs, medicare, medicaid, practically all of them are based upon the fact that you have got to get good and sick before you could get any advantages.

Somebody once told me that the Chinese, years and years ago, used to have a program or set of principals that related to medical care that they only paid the doctor when you were well; that you didn't get paid if you were sick.

In other words, the doctor had to take care of you if you were sick but that proved that he had been a failure.

If you were well, the doctor got paid.

Now, I suppose that that is mythology rather than fact.

Yes, Mr. Pollack?

Mr. POLLACK. Mr. Chairman, if we had rationally developed our health insurance scheme rather than starting with hospitalized illness, we might very well have started with diagnostic procedures and then go on from there to determine what other services might be covered.

I would call your attention to the fact that in our plan we suggest what is really a heroic turnabout, that our program would have preventive and diagnostic services starting with its very first phase, and by the second phase would be deeply involved in providing this type of care, so at last we would have a health system.

We even go further than that. We have essentially a care-oriented system. It simply pays out a certain number of dollars for care that is assumed to be necessary.

We propose a rather basic conversion of the entire system so that it really looks at health and what it takes to keep people healthy.

We would return to that Chinese——

Chairman HUMPHREY. Yes, I get your point, very much so.

Dr. Cooper, you have listened and been most patient while we have all listened and talked.

What are your observations on some of the suggestions that have been forwarded here?

We are really looking at two things in this committee when the subject is consumer economics, obviously, health care costs, preventive, diagnostic or curative are all a part of the cost of living today, and in my opening statement I was emphasizing that those costs have increased sharply, and because they have increased sharply, it becomes a factor that relates to spendable income, whether or not you have any savings, what your indebtedness is, and of course what your paycheck needs to be.

Do you have any general observations on, for example, Mrs. Davis' presentation and Mr. Neal's?

Dr. COOPER. Well, I think as we have stated many times that in order to really confront the problems that you raise, we do have to develop some sort of a national health system which this country does not have.

I have stated that we are still in the age of the pushcart vendor when really we should be in an age of supermarkets, and until we get some rationalization system, there will be very little ability to control the costs.

I think that the very points that have been raised by both Mrs. Davis and Mr. Neal, in addition to thinking only about physicians being involved in care, as I stated, we need to turn our attention to the development of teams with appropriate authority and responsibility for other health professionals to carry on those aspects of prevention, diagnosis, and treatment which don't require the sophisticated skills of physicians.

We have shown, for example, in pediatrics, 80 percent of all skills and prevention—and they have one of the most advanced programs—can be carried on by nurses and pediatric practitioners.

Similar studies have been done in Boston and other places in the same kind of percentages, whether they are 80 or 90 is not important, for adult primary care can be carried out by others in the context of a health care system in which the physician is the most highly educated and skilled.

By the development of these teams alone, we could maybe quintuple or quadruple the number of effective physicians we have today, and it would make primary care, which is one of our major problems in accessibility and cost, make it a more attractive specialty for physicians, since they would have the challenges the specialist has for these cases which require their skill, and they would have available to them the others who could carry on the care for the less demanding diseases.

It is particularly true in the changing nature of pattern of disease.

In the 1930's people went to physicians when they were acutely ill, and they either were cured or died, and they didn't see the physician until they were acutely ill again, as your mother.

Now, the nature of diseases changed. For example, let us take a moment in hypertension, a disease which before World War II was a sentence of death for a young man and the physician used to really tell him: Go and see your lawyer.

Now we have methods to control that disease over long periods of time.

The intervention of physicians all along this is not necessary. You can turn this over to others working with the physician to maintain the monitoring.

The same with diabetes, chronic kidney disease, and so on.

I agree if we are to really have any rationalization system, we have to do something about getting it organized in a way that we can effectively and efficiently use the people and resources we have and through this possibly not reduce the cost as much, although there would be some cost-effectiveness here, but improve the quality and the amount of health care that can be delivered to all people, because I think health care in modern times, unless we really understand the disease, is expensive.

We need, as I said before, to get rid of that expense by understanding the disease and preventing it first. That is the fundamental which we must continue to harp on as one of the major cost-effectiveness approaches, and that is to get rid of the disease by preventing it.

Chairman HUMPHREY. What disturbs me a great deal as I look at the Federal budget, which by the way is the only planning instrument that we have at the Federal level today, most of which is a fiscal year basis which is far too short a period of time, as I look at that I fail to see any cohesive or interrelated or projected plan of action to accomplish what you have mentioned here or what you have just related to, Dr. Cooper; is that your judgment?

Dr. COOPER. Yes. There is no plan.

For example, the biomedical research area is to be severely cut except for some categorical diseases, and although these are diseases which bring a great deal of heartbreak, they don't constitute the major disease burden of the country. Cuts in other areas severely hurt our ability to advance knowledge against these diseases.

Chairman HUMPHREY. I alluded earlier in the article that appeared in yesterday's Washington Post, "Funds May Be Cut From Medical Schools; Georgetown and George Washington Medical Schools are on the verge of closing their doors."

Is there just two isolated cases or is this symptomatic?

Dr. COOPER. The proposed budget cuts affects both public and private medical schools. The problem faced by those schools is not an isolated incident. One of the first things that will suffer is the quality of the educational programs. Following that, if they are severely compromised, there will be accreditation problems and a reduced number of spots for educating health professionals.

The schools simply don't have the kind of funding that permits them flexibility. They cannot take the opportunity to do the kinds of things we have just talked about. They are more concerned with keeping body and soul together and not thinking great thoughts about new things they could undertake.

This will substantially delay the progress we were beginning to make in confronting some of the problems you have just talked about.

Chairman HUMPHREY. I would like to get the judgment or the views of the other panel witnesses this morning on the budget as it relates to health care, medical research, training of nurses, medical technicians, dental field, et cetera.

Mrs. Davis, would you care to comment on your observations?

Mrs. Davis. Following up what Dr. Cooper said, I think it is important to promote the use of paraprofessionals.

He mentioned pediatric nurse assistants; there are a number of other paramedical aides in specific areas. Some organizations which have used these personnel are many of the service delivery programs, such as neighborhood health centers and community mental health centers.

These service delivery programs are threatened in the new budget—support of community mental health centers is being phased out and support of other service programs is being kept constant.

More funds should be made available to those programs experimenting with paraprofessional personnel.

On the Hill-Burton program, Mr. Neal mentioned that this program has served a lot of functions and is being abandoned on the basis of one objective of the program—to expand hospital beds.

Now, I agree that in general there is no acute shortage of hospital beds, but there are other needs. Many hospitals need to be modernized.

A large portion of Hill-Burton funds currently go for that purpose. A large portion of funds go for construction, expansion, and modernization of out-patient clinics. This is still a much needed effort.

Many central city residents face a shortage of physicians and must rely upon hospital out-patient clinics as a source of primary care.

I would not like to see the Hill-Burton program terminated, at least until we have some other program that meets these needs for ambulatory facilities.

In the area of training we have heard a lot about medical schools, not so much about the other health professional schools where capitation grants have been terminated entirely.

These changes are particularly severe in magnitudes and timing with cuts coming very quickly, and it is very difficult for the education profession to adjust to these rapid changes.

If in the long run, we were to put in other types of programs like extensive scholarship programs which would help nurses, for example, attend nursing school or extensive scholarship programs for medical schools, then it might be possible for schools to generate more revenues from students without harming the socioeconomic balance of students entering the health profession. I think the important thing is the timing and the magnitude of the cuts. There might be better ways in the long run by which to generate revenues for training, but without the presence of these programs at present, it can lead to very severe financial problems for existing medical institutions.

Chairman Humphrey. What disturbed me most, ever since Truman's program on health care in 1948, in that period, we have been talking rather glibly about the need for a rather rationalized, better organized system of health care delivery, which of course includes the professional personnel, the paraprofessional personnel, the facilities, the whole spectrum of health care services and personnel.

We have been talking about it and talking about it. We have gotten into big arguments whether it ought to be national health insurance under social security, and I think the question ought to be posed now, do we have a better health care service today than we had, let's say, 10 years ago?

We know it costs more. There is no doubt about that. The cost is very significant.

I think, Mr. Neal, you indicated, or one of you indicated that the cost has been about half again as much in terms of rising cost as in other items that go in the consumer's budget.

How would you classify or characterize the existing health services, including manpower facilities, the whole spectrum of professional personnel?

Do you consider it—well, what label would you put on it?

Dr. Cooper. We make a comparison with other countries, for example. At the present time, the United States has about 165 physicians per hundred thousand population.

We have about 900 health personnel per physician. The highest physician-populated ratio is in Israel, because of the immigration situation; they are up to around 250. The Soviet Union has 237 physicians per 100,000.

Countries that do provide health care or accessibility to health care for all their people, for example, Sweden, Great Britain, and others, are below us in the number of physicians per population.

In part it has to do with the organization of the use of our resources.

But when we take into account our total professional pool, we far exceed any nation in the world in the ability to deliver health care.

Chairman Humphrey. You mean in terms of numbers and facilities?

Dr. Cooper. Yes, sir.

Chairman Humphrey. Again, am I correct, and it does seem from your comment it is the organizational structure which is lacking and which promotes the inefficiencies and lends itself to the high costs?

Dr. Cooper. Yes, sir, or to the lack of accessibility for a large fraction of our population, which has been pointed out.

Someplace between 20 and 40 million people in this country simply do not have adequate health care. That is a very large portion of the population for a country that at least, until recently, was considered to be more affluent than any other country in the world.

Chairman Humphrey. Mrs. Davis, do you have any other comment?

Mrs. Davis. No, sir.

Chairman Humphrey. Mr. Neal or Mr. Pollack, just feel free to join in.

Mr. Neal. Could I call your attention to a statement which was attached to my prepared statement, a telegram from Marion Folsom, former Secretary of Health, Education, and Welfare, a member of the committee that drafted our statement, and a great proponent of improvements in the delivery system. He says:

> The health people in the Rochester area are greatly disturbed over the drastic reductions in the health program proposed by the administration. The Rochester area has received meaningful grants from the Department of HEW and the previous administrations over the past years.
>
> These grants have been matched by dollars from local sources and have been in the forefront of new developments in health services. This sudden and sharp reduction will greatly affect the health care of the area. It will set us back in the areas where we have begun to make real progress. I strongly urge that a more selective basis be used to bring about reductions. Savings may be made by postponing the Hill-Burton program and manpower and other long-range programs, so that the more effective program can be continued.
>
> The Rochester experience is a clear demonstration of the objective of President Nixon that Federal funds be used to encourage the private sector to marshal its resources.

Its complaint is that having done it, they are being left high and dry.

Chairman Humphrey. How would you characterize the current budget, the fiscal 1974 budget, as it relates to this limited field of health care? I will let you put your own labels on it if you wish to.

Mr. Neal. I think the spirit of this telegram is appropriate evidence that there has been an abruptness and a lack of planning in carrying out the proposed reductions, but I would prefer to defer to Mr. Pollack.

Chairman Humphrey. Mr. Pollack.

Mr. Pollack. Perhaps you can visualize it somewhat more clearly if you look at the health facilities.

Our Nation ought to be aware of the fact that its health facilities are really in more serious shape today than they were in 1946, when the Hill-Burton Act was first passed. It is true we have lots of hospital beds, and I think I can demonstrate in many areas of the country we have a surplus of beds, and if we are not careful, we will have a surplus of nursing home beds if we continue to operate in the old unplanned way.

But we don't have an excess of facilities in all. As a matter of fact, looking at facilities in the aggregate, we have very serious shortages of some kinds.

One of them has to do with reduction in costs with the result we don't have enough ambulatory facilities in their neighborhood and newly conceived so that they provide for the kind of primary care and comprehensive care and assisting building activities that are needed.

We have conceived of facilities in such a narrow way that we don't realize that the home is probably the dominant health facility, and it needs enormous development.

I am not proposing building homes, but the home could be used more with videophones and telemedicine and provide them effectively so that the physician could rapidly replace the rapidly vanishing home call, as one illustration.

I would like to go a little further. We have thought about obsolescent facilities in the old Hill-Burton framework. Even the Hill-Burton criteria show that we have a very serious problem of dimensions, of obsolescence that are staggering and in many respects—well, you have the figures, I am sure, and I will be glad to supply them.

However, we have looked only at physical obsolescence. In addition to physical obsolescence, we now have social obsolescence, the fact that the old outpatient facilities are no longer acceptable socially.

We have wards that have just been refurbished slightly to look like semiprivate accommodations that are really no longer acceptable to our people; there is environmental and locational obsolescence.

Many of our facilities are in the wrong places now, and, as a matter of fact, some of our facilities have contributed to the blight, adding to their own obsolescence as well, and largely unrecognized is the fact that we have medical obsolescence in a lot of our facilities, especially the small hospital, maybe in a large urban area, is a medical anachronism.

If we started looking at what is needed fundamentally, the kinds of facilities that we ought to have we will arrive at a conclusion, and I would like to read this, because I think it is well considered.

Dr. Maloney, the dean of Tufts Medical School, and another outstanding architect and myself, did a study 2 years ago on health facilities, and we concluded, sir, that our Nation today is unprepared to provide proper facilities in scale with its perceived needs, aspirations, and current concepts of care; that it is unprepared to back up facilities, its determination to assure all people of the care they need; unprepared to provide the facilities required for improved delivery system it deems imperative; and in brief, unprepared to provide a proper environment in which to care for the American people today and certainly tomorrow.

To conclude, many of us recognize that the Hill-Burton program needs a change.

Several years ago, there was a flurry of consideration as to how the Hill-Burton program could be amended to embrace broader objectives and foster comprehensive services and promote better methods of financing facilities in the future.

That really wasn't done. All we did was patch up the Hill-Burton program as we did the old facilities.

At this point, rather than abandoning the Hill-Burton program, we ought to develop a new one. Options are very simple: We will see it abandoned and then have to redo something or prolong it and reorganize it. We will not be able to get a new system started if we don't attend to the entire system, including the facilities.

As the originator of one new system, I find that it was the facility requirement that simply determined our ability to get started. You can't build a new program without having one.

Chairman HUMPHREY. Do you find anything in the present budget outlays that indicate remedies such as you have suggested?

Mr. POLLACK. There is a partial recognition. There are efforts to expand support for new systems, including some of the facilities.

Yes, that is positive. But the larger address to facilities has been lost with the proposed elimination of the Hill-Burton program.

Chairman HUMPHREY. Any other commentary from any of our witnesses here? Let me just thank you very much for coming.

I want just to kind of wind this off by an observation that has been running through my mind for a long time. Generally, the discussion in the country on health care today is over how we are going to pay for it.

I think that, of course, is very important. But there hasn't been sufficient discussion on how we will organize it, which I think you have talked about this morning, which you have directed your attention to very well; nor have we had sufficient discussion or decision as to where the gaps are, where the fill-in needs to be made, where the extensions need to be undertaken or authorized.

We have permitted ourselves to get into the arguments of the professional groups and the consumer, the American Medical Association on one hand and some of the labor groups on one hand, as to whether it ought to be a social security type of health insurance or whether it ought to be a private type of health insurance, when, in fact, I am convinced this morning, if we were to have health insurance this morning, we wouldn't be able to take care of the health care problem at all.

I happen to be a supporter of a broad comprehensive program of national health insurance, but I am even more in support of getting

ourselves organized or at least getting a plan of action, and this is what I see is so lacking.

After all of these years of discussion, with all of the people we have working on these problems, we still haven't formulated a plan of action.

Today we have the HMO debate, you hear in the Senate with a plan of action. The HMO's, I think, offer good insensitive or good structure organization. I think that is a forward step, but we are doing all of this piecemeal.

I still do not see the interrelationship, the planning that goes into what our medical schools, dental schools, osteopathy schools, nursing, et cetera, what the professional manpower needs are as compared to what the new facility needs are, and I surely agree with you, Mr. Pollak, that even if you have a structurally sound hospital, it doesn't mean that it is really serving properly or adequately the health care needs in terms of hospitalization.

Many of the facilities are socially and structurally out of date; they really are, and their cite location is wrong. There are many things we could look at.

One of these days, I am hopeful that men and women of your quality and ability and knowledge will be able to pull together a program. I have spoken across the country and said some of us up here in Congress will have to do it and it will be a Rube Goldberg special with piece by piece together and end up with an inadequate system.

I had hoped we might get some action out of the statesmen and the structural specialists, the medical philosophers and the consumers and doctors all put together to give us a plan of action.

We don't have it. What we have is critical analysis of the inaction. We still do not have a plan of action.

Senator Javits, we have been discussing this morning the health costs, and, of course, the factors that relate to these health costs.

We have had some excellent testimony here which I am sure much of which you in the past have heard because of your service on the Labor and Public Welfare Committee.

But it is surely a fact of life now that health care costs are a significant factor in the increase in the cost of living.

I might add that the lack of health care is an even greater significant factor in the cost of living.

There is nothing more costly than not being able to work or perform up to your capacity or just sort of lagging along at about 75 percent of your ability to do a job.

I have often wondered how many people really just never feel good, you know, and are really unable to truly perform.

It is sort of like an economy that has a 5 percent unemployment; it is a person with a low-grade fever; you are able to report to work and punch the time clock, but about 3 o'clock in the afternoon, you hate everybody and you are not really doing your job.

Senator Javits.

Senator Javits. Thank you, Mr. Chairman.

I just came to show my interest in what the Chair was doing in carrying on this effort to inquire into the reasons for major increases in the cost of living in depth.

I am deeply concerned with the same problem, medical care costs and health care delivery in the organization.

We are dealing with it right now on the floor in the HMO bill, which I am hoping we will settle within then next few hours.

I just join the Chair in thanking the witnesses and assuring them there are a number of us here who will do our utmost who will bring about, (1) A national system of health care, (2) facilities and services to man it, and (3) a rationalization of the cost and a division of the costs which will reflect widespread participation which is the only way these costs can really be brought down.

I thank the Chair very, very much for this opportunity.

Chairman HUMPHREY. I want to thank you, too. I could spend the rest of the day visiting with you about this in terms of experimental hospitals to reduce costs, experimental community neighborhood health centers.

We just build one and say that's it. We are not really willing to do the kind of experimentation that could improve the delivery system.

Tomorrow, we have Charles Edwards, Assistant Secretary for Health, with us at 10:30 a.m.; and Mr. Glenn Wilson, associate dean, School of Medicine, University of North Carolina.

We will discuss with them the adequacy of the budget.

I want to leave you with this thought: that that Federal budget determines an awful lot what you are going to be able to do, and therefore, your analysis of that budget in terms of how it ought to be adjusted, the allocations that ought to be made are highly significant to every Member of this Congress because we cannot talk health care in America without considering the Federal impact of this, and you cannot shift all of this to State and local governments.

This idea that there is another way you can get the funds out of some other public resource, that may be down the road a number of years by the time you are able to readjust tax structures and get a better tax basis and find other sources of revenue.

But a dislocation either by a massive infusion of Federal funds or a substantial reduction, either one of them, I think is very serious; and above all, the hills and the valleys, the ups and the downs, the uncertainty, the inability to plan, I think that the Federal budget reductions cause, those reductions are going to have a very crippling effect upon our medical and health programs.

How can a dean of a medical school look down the road the next few years—you have to plan in terms of years, not months—and say, well, I think by 1980, we will be able to produce the following, or by 1977, 4 years, or 1976.

There is no way; there is just no way unless you have some indication from authorities that you can depend at least upon a certain percentage of your total outlay to be Federal support or they just give you the word and you go through a period of utter confusion for a while that you can just forget it and then maybe you can make some plans to do much less than you are doing.

With that, it is a happy note, I will recess the hearing. Thank you very much.

[Whereupon, at 12:30 p.m., the subcommittee recessed, to reconvene at 10 a.m., Wednesday, May 16, 1973.]

MEDICAL POLICIES AND COSTS

WEDNESDAY, MAY 16, 1973

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON CONSUMER ECONOMICS,
JOINT ECONOMIC COMMITTEE,
Washington, D.C.

The subcommittee met, pursuant to recess, at 10:40 a.m., in room 4221, Dirksen Senate Office Building, Hon. Hubert H. Humphrey (chairman of the subcommittee) presiding.

Also present: John R. Stark, executive director; Loughlin F. McHugh, senior economist; Michael J. Runde, administrative assistant; Jerry J. Jasinowski, L. Douglas Lee, and Courtenay M. Slater, professional staff members; Leslie J. Bander, minority economist; George D. Krumbhaar, Jr., minority counsel; and Walter B. Laessig, minority counsel.

OPENING STATEMENT OF CHAIRMAN HUMPHREY

Chairman HUMPHREY. I have a brief opening statement; then we will proceed with our witnesses. I believe our principal witness today is Dr. Charles Edwards. He is accompanied by Dr. Zapp and Mr. Altman.

Am I correct in that?

Dr. EDWARDS. That is correct, Mr. Chairman.

Chairman HUMPHREY. This morning, the Subcommittee on Consumer Economics continues its investigation of the Federal role in providing adequate health care to the American people at a reasonable cost.

Might I say for the benefit of our witnesses, we have been looking into the different areas of the economy as those areas affect the cost of living index, the consumers' needs, and the consumers' resources. We have been in the area of food prices, industrial prices. We are now in gasoline energy, fuels, now on health, later on—on housing. So we are kind of covering what you might call the spectrum of the major factors in the consumers expenditures for services and products necessary for, hopefully, a reasonably good standard of living.

The medical services component of the Consumer Price Index increased at a 5 percent annual rate in the 6 months ending in March of this year. This is in a period when the medical sector of the economy is under much tighter controls than the rest of the economy. In some areas, particularly hospital care, price rises may be even worse. Yesterday, I put into the Congressional Record the study made by Blue Cross and Blue Shield in the State of Minnesota, showing that hospital care costs have gone up 7.9 percent this past year in the city of

Minneapolis, 7.7 percent throughout the entire State of Minnesota, and this at a time when there are supposed to be rather tight controls on hospital costs. This did not include pharmaceuticals, which I know from personal observation continue to climb in costs, for what reason, I do not know; but they continue to go up.

The testimony before this subcommittee yesterday gives me little hope that we can expect any moderation in the foreseeable future. In fact, the indications are that the impact of the proposals made in the 1974 budget may aggravate the problem. I would call to the attention of our witnesses today the testimony yesterday of Dr. Cooper, of the American Association of Medical Colleges, Mr. Neal, of the Committee for Economic Development, and Mrs. Davis, of the Brookings Institution. Dr. Cooper, for example, released a survey by the Association of American Medical Colleges which shows that in medical schools—the very foundation of modern medical care—funds for research and teaching will drop 15 percent from 1973 to 1974, and one of every 12 faculty members will have to be released from employment. We also brought to the attention of our record and witnesses yesterday the story that appeared in the Washington Post on Monday morning where two of the great medical schools in this area, Georgetown and George Washington University, are facing serious economic problems and may very well have to close. I doubt that that is going to happen. I do not think we can afford to let it happen.

I might also add that I brought to the attention of our witnesses the flagrant violation of contract on the part of the Government of the United States with the University of Minnesota in its unwillingness to fulfill contract obligations that it entered into 2 years ago to provide assistance for the expansion of the university medical school. That was a contract entered into with the Department of HEW to expand the number of general practitioners and to provide general practitioners in particular for rural areas. Now, the State of Minnesota, in legislative session, appropriated $13 million for our side of it. The Government of the United States is apparently broke except for dropping bombs in Cambodia and could not afford to come up with its share of it. I am going to bring this up every time I see a government witness. Law and order has been violated.

Mrs. Karen Davis showed in her testimony that the impact of the medicare and medicaid proposals on elderly people could be disastrous. Under current laws, a patient hospitalized for 30 days would pay an estimated $84 out-of-pocket. But under proposed legislation, he would pay an estimated $400; according to Mrs. Davis.

Mr. Alfred Neal of the CED testified that with our current health-care delivery system, a national health insurance plan alone would be a "disservice to the Nation." We must reform the organization of our health delivery system if it is to be able to withstand the pressures generated by a national health insurance plan.

An examination of the 1974 budget seems to show this administration plans to commit fewer and fewer resources toward solving health care problems. Looking at the budget requests for HEW health programs shown in the 1974 budget, omitting from consideration the funds for medicare, medicaid, and the advance funding for community mental health centers which are being phased out, the requested authorizations for health programs go from $4.6 billion in 1972 to $4.1 billion in 1973 and $4.3 billion in 1974. Those figures, of course, ignore

the blatant fact of inflation. These minimum proposed authorizations are disturbing on their face, but if we look at the health budget in real purchasing power terms, these administration requests are shocking. Assuming only a 5 percent rate of inflation continues, we would need to authorize $742 million more than the budget asks in 1973 and $797 million more in 1974 just to maintain the 1972 level of Federal support for HEW health programs.

Equally distressing is the apparent total lack of any overall health strategy. For years, we have talked about the need for comprehensive planning to direct our health effort, but this budget seems to continue a patchwork, hit-or-miss approach. It proposes cutting out programs long before any new programs can be substituted for them according to the testimony of the most competent witnesses from our medical schools. Funds budgeted for improving the organization and delivery of health services actually decline from $670 million in 1973 to $640 in 1974.

I simply cannot see how the priorities reflected in this budget will contribute significantly in either the long- or short-run to solving the problems that consumers face in trying to obtain adequate medical care at prices they can afford to pay.

I might also add that considerable discussion took place yesterday by the witnesses, all of whom I consider to be objective, surely not radical, most likely conservative, and indeed, very thoughtful; that those witnesses commented upon the cancellation of Hill-Burton funds, not as it relates to hospital construction particularly, but modernization and certain types of health care facilities which are no longer permitted under Hill-Burton.

Dr. Edwards, we are very pleased that you are with us today to discuss some of these problems which concern us both. I am very familiar with your record and background and I consider it a commendable one. I know that you will have some material for us which can be helpful. I have already introduced your associates, so it will not be necessary to do that.

Proceed.

STATEMENT OF HON. CHARLES C. EDWARDS, M.D., ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY JOHN S. ZAPP, D.D.S., DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH); AND STUART H. ALTMAN, DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (HEALTH)

Dr. Edwards. Thank you, Mr. Chairman. If I could, I would like to go over that part of my prepared statement that relates mainly to the general issues and then speak to the specific issues as it relates to any questions that you might have.

Chairman Humphrey. Yes, thank you.

Dr. Edwards. The analysis within both HEW and other responsible administration agencies that led to development of the 1974 health budget focused upon several important and unmistakable problems which had been perceived in past years, but which had been either prematurely dismissed or inadequately dealt with. In accordance with the President's determination that the administration's budget would

not exceed reasonable projections of Federal funding ability without increased taxation, these issues had to be met head-on. We had to make realistic assessments of the effectiveness in terms of the Federal funds invested in them. We could not condone funding merely for the sake of keeping a program going for another year.

Beyond doubt, the major Federal health financing programs—Medicare and Medicaid—have substantially improved access to health care for millions of the aged and the poor. But these accomplishments have been compromised in some very disturbing ways. The rise in buying power has contributed to an unprecedented rise in the cost of health services and thus escalated Federal outlays far beyond those originally predicted. More important, inflation has seriously eroded the value of health purchasing dollars in every American family.

In an effort to curb the inflation which has so sorely afflicted the health care field, the administration already has launched a coordinated program designed to control medical costs. As you well know, President Nixon specified that health was to be one of only three sectors of the economy to be continued under mandatory controls during phase III of his economic stabilization program.

To assure that the Federal approach to helping solve the cost program is concerted and integrated, Secretary Weinberger has been made a member of the Cost of Living Council and of its Cabinet-level Health Committee.

The impact of the economic stabilization program on the health sector has already had a clear and demonstratable effect on prices. Prior to August 1971, the medical care component of the CPI was rising at an annual rate of over 6.5 percent. Physician fees were increasing at 7.1 percent and hospital charges as measured by hospital room and board rates were increasing at 12.8 percent. On all three fronts there has been a notable improvement. The CPI index for medical care during 1972 increased by only 3.2 percent. Physician fee increases were kept to 3.1 percent and the hospital room and board change showed the smallest rate in years (6.6 percent).

Nevertheless, the problem is far from solved. Total hospital care expenses per patient day continue to rise at uncomfortably high rates. For the 1971–72 period, expenses per patient day climbed at an annual rate of 11.6 percent. This is down somewhat from the 14 to 15 percent rates of the late 1960's and early 1970's, but still is climbing at levels considered to be unacceptable.

It is in this area we expect to concentrate our major efforts during phase III of the economic stabilization program. We anticipate that within the next week or two a distinguished group of health care leaders will be appointed to a Health Industry Advisory Committee of the Cost of Living Council. This advisory committee will have as its first assignment a thorough review of the economic stabilization health care regulations.

The administration is also seeking several modifications of the social security laws to address these problems. We have proposed to modify copayment provisions for hopitalization under medicare to decrease excessive utilization of this expensive form of treatment. We are also seeking certain refinements of the medicaid program to help control the rise in costs.

We are also, under the provisions of Public Law 92–603, setting in motion the machinery to establish a network of professional stand-

ards review organizations whose prime function will be to make certain that health care reimbursed under medicare and medicaid is fully warranted by the needs of the patient and consistent with the best standards of medical practice in the area. This PSRO effort, together with other utilization and quality review initiatives, can have a very beneficial effect on the serious problems that beset medicare and medicaid, as well as other third-party financing systems. These new initiatives can have a very beneficial effect on the problems of health care financing that concern us all, but they do not do away with the need to assess the values and accomplishments of existing programs. In our judgment, Federal efforts to improve the efficiency of health care delivery, to expand available health resources, and to enhance the quality and effectiveness of health care have, under scrutiny, proved not as successful as we might have hoped.

Some would argue that we have not spent enough, that we have not given these efforts sufficient time or money to accomplish their purposes. Frankly, I do not think these conclusions are supported by the facts. On the contrary, I think we have seen that the infusion of billions of Federal dollars into the American health enterprise has failed to solve some of the problems that have plagued that system for decades, and in some cases made matters worse than before.

I believe the path out of this dilemma is not simply more spending, but rather more intelligent use of Federal health dollars.

It is, in my judgment, high time to insist that the people of this country receive a full return on the investment of a sum equal to nearly 10 percent of the entire Federal budget, a return that can be measured in improved health, not just further inflation, health care cost inflation.

With that objective in mind, we have proposed to terminate a number of Federal assistance programs that (1) have either served their purpose and now should be financed by other permanent sources, or (2) have had no clear and essential purpose to serve.

At the same time, we have proposed increases in other health activities that appear to offer significant opportunities for improving the health of the American people.

Some of these changes are unpopular with those segments of the health enterprise that have become accustomed to steady increases in Federal support. Even before the President submitted his budget to the Congress, strenuous protests began to be heard from individuals and organizations interested in the continuation and expansion of one or another Federal health activity. These protests can be expected to reach a crescendo before the end of this fiscal year when many of the affected authorities expire.

We are certainly not indifferent to these protests, nor do we expect the Congress to be. But we cannot accept the proposition that our only choice is to cling to the patterns of the past. Instead, we must clearly define the proper Federal role in health and then begin to measure various individual proposals for Federal intervention against this definition. Only then can we assign priorities based on actual needs and realistcally measure progress in meeting these needs.

Let me define for you briefly our perception of the Department's share in the proper Federal role in health:

First priority should be placed on reducing financial barriers that limit access to needed health care. This is primarily accomplished

now through the medicare and medicaid programs; it will be furthered by enactment of a sound national health insurance program on which we will soon be making our recommendations to the Congress;

There should also be Federal support for health and medical research. The benefits of this activity are national in scope, and high investment costs make ongoing support from the private sector or from State and local governments unreliable at best.

Many preventive health and consumer protection activities are also appropriately Federal concerns in the collective national interest. Controlling the hazards inherent in the use of drugs, preventing and checking food and cosmetics adulterations and checking the spread of communicable disease clearly involve a Federal responsibility. Traditional public health concerns such as epidemics across State lines and quarantine requirements fall into this class, although we think the States have a major responsibility here as well.

A more limited Federal role and increased reliance on the capabilities of local public and private sectors are indicated in the following situations:

Startup funding for demonstration of new facilities or services which should be time limited and which should incorporate from the outset feasible takeover financing from permanent alternate sources;

The direct provision of health care to segments of the population whose right to such care is recognized in law or whose need is especially acute because of the failure of more traditional means of providing health services:

The education of health manpower which cannot be accomplished through the basic student assistance programs offered by the Office of Education which are essential to meet especially difficult supply problems with respect to certain professions (for example, physicians and dentists) or to assure proper geographic distribution of health personnel or demonstrate the role of new types of health workers.

With these principles as guides, we can now examine briefly some of the highlights of the fiscal year 1974 budget.

Total health spending in 1974 proposed in the President's budget for the Department of Health, Education, and Welfare would reach $21.9 billion, $3.5 billion more than our current estimate for 1973, and nearly double the amount spent in 1969. I need hardly point out, however, that a major factor in this increase is the continuing uncontrollable rise in payments under medicare and medicaid resulting from expanded coverage, increasing utilization, and inflation in the cost of health care. But we are also proposing significant increases in certain of the controllable portions of the health budget, specifically in cancer and cardiovascular research and consumer protection. Our strategy in the allocation of these controllable funds is aimed, in major part, toward strengthening the Nation's ability to achieve better health without feeding the inflationary spiral but that diminishes the value of every dollar we spend.

Mr. Chairman, I would like to conclude at that point, and any questions, we would be delighted to attempt to answer.

[The prepared statement of Dr. Edwards follows:]

PREPARED STATEMENT OF HON. CHARLES EDWARDS, M.D.

Mr. Chairman and members of the subcommittee, I am pleased to respond to your invitation to discuss the health portion of the 1974 budget for the Department of Health, Education, and Welfare and the activities which this Administration is undertaking to contain increases in the costs of health care.

DEVELOPMENT OF THE ADMINISTRATION'S HEALTH BUDGET

The analysis within both HEW and other responsible Administration agencies that led to development of the 1974 health budget focused upon several important and unmistakable problems which had been perceived in past years, but which had been either prematurely dismissed or inadequately dealt with. In accordance with the President's determination that the Administration's budget would not exceed reasonable projections of Federal funding ability without increased taxation, these issues had to be met head-on. We had to make realistic assessments of the effectiveness in terms of the Federal funds invested in them. We could not condone funding merely for the sake of keeping a program going for another year. Furthermore, we had to assess the potential for shifting financial responsibility to non-Federal sources, public and private.

Beyond doubt, the major Federal health financing programs—Medicare and Medicaid—have substantially improved access to health care for millions of the aged and the poor. But these accomplishments have been comprised in some disturbing ways. The rise in buying power has contributed to an unprecedented rise in the cost of health services and thus escalated Federal outlays far beyond those originally predicted. More important, inflation has seriously eroded the value of health purchasing dollars in every American family.

In an effort to curb the inflation which has so sorely afflicted the health care field, the Adiminstration already has launched a coordinated program designed to control medical costs. As you well know, President Nixon specified that health was to be one of only three sectors of the economy to be continued under mandatory controls during Phase III of his economic stabilization program.

To assure that the Federal approach to helping solve the cost program is concerted and integrated, Secretary Weinberger has been made a member of the Cost of Living Council and of its Cabinet-level Health Committee.

The impact of the Economic Stabilization Program on the health sector has already had a clear and demonstratable effect on prices. Prior to August 1971, the medical care component of the CPI was rising at an annual rate of over 6.5 percent. Physician fees were increasing at 7.1 percent and hospital charges as measured by hospital room and board rates were increasing at 12.8 percent. On all three fronts there has been a notable improvement. The CPI index for medical care during 1972 increased by only 3.2 percent. Physician fee increases were kept to 3.1 percent and the hospital room and board change showed the smallest rate in years (6.6 percent).

Nevertheless, the problem is far from solved. Total hospital care expenses per patient day continue to rise at uncomfortably high rates. For the 1971–72 period, expenses per patient day climbed at an annual rate of 11.6 percent. This is down somewhat from the 14 to 15 percent rates of the late 1960's early 1970's, but still is climbing at levels which the Administration considers unacceptable.

It is in this area we expect to concentrate our major efforts during Phase III of the Economic Stabilization Program. We anticipate that within the next week or two a distinguished group of health care leaders will be appointed to a Health Industry Advisory Committee of the Cost of Living Council. This Advisory Committee will have as its first assignment a thorough review of the Economic Stabilization Health Care Regulations.

The Administration is also seeking several modifications of the Social Security laws to address these problems. For example, we have proposed to modify copayment provisions for hospitalization under Medicare to decrease excessive utilization of this expensive form of treatment. We are also seeking certain refinements of the Medicaid program to help control the rise in costs.

Further, in this connection, as you know, we are, under the provisions of P.L. 92–603, setting in motion the machinery to establish a network of Professional

Standards Review Organizations whose prime function will be to make certain that health care reimbursed under Medicare and Medicaid is fully warranted by the needs of the patient and consistent with the best standards of medical practice in the area. This PSRO effort, together with other utilization and quality review initiatives, can have a very beneficial effect on the serious problems that beset Medicare and Medicaid, as well as other third-party financing systems. These new initiatives can have a very beneficial effect on the problems of health care financing that concern us all, but they do not do away with the need to assess the values and accomplishments of existing programs. In our judgment, Federal efforts to improve the efficiency of health care delivery, to expand available health resources, and to enhance the quality and effectiveness of health care have under scrutiny, proved not as successful as we might have hoped.

Some would argue that we have not spent enough, that we have not given these efforts sufficient time or money to accomplish their purposes. Frankly, I do not think these conclusions are supported by the facts. On the contrary, I think we have seen that the infusion of billions of Federal dollars into the American health enterprise has failed to solve some of the problems that have plagued that system for decades, and in some cases made matters worse than before.

ADMINISTRATION'S HEALTH STRATEGY

I believe the path out of this dilemma is not simply more spending, but rather more intelligent use of Federal health dollars.

It is, in my judgment, high time to insist that the people of this country receive a full return on the investment of a sum equal to nearly ten percent of the entire Federal budget, a return that can be measured in improved health, not just further inflation.

With that objective in mind, we have proposed to terminate a number of Federal assistance programs that have (1) have either served their purpose and now should be financed by other permanent sources, or (2) have had no clear and essential purpose to serve.

At the same time, we have proposed increases in other health activities that appear to offer significant opportunities for improving the health of the American people.

Some of these changes are unpopular with those segments of the health enterprise that have become accustomed to steady increases in Federal support. Even before the President submitted his budget to the Congress, strenuous protests began to be heard from individuals and organizations interested in the continuation and expansion of one or another Federal health activity. These protests can be expected to reach a crescendo before the end of this fiscal year when many of the affected authorities expire.

We are certainly not indifferent to these protests, nor do we expect the Congress to be. But we cannot accept—nor do we expect the Congress to accept—the proposition that our only choice is to cling to the patterns of the past. Instead, we must clearly define the proper Federal role in health and then begin to measure various individual proposals for Federal intervention against this definition. Only then can we assign priorities based on actual needs and realistically measure progress in meeting these needs.

Let me define for you briefly our perception of the Department's share in the proper Federal role in health:

> First priority should be placed on reducing financial barriers that limit access to needed health care. This is primarily accomplished now through the Medicare and Medicaid programs; it will be furthered by enactment of a sound national health insurance program on which we will soon be making our recommendations to the Congress;
>
> There should also be Federal support for health and medical research. The benefits of this activity are national in scope, and high investment costs make ongoing support from the private sector or from State and local governments unreliable;
>
> Many preventive health and consumer protection activities are also appropriately Federal concerns in the collective national interest. Controlling the hazards inherent in the use of drugs, preventing and checking food and cosmetics adulterations and checking the spread of communicable disease, clearly involve a Federal responsibility. Traditional public health concerns such as epidemics across State lines and quarantine requirements fall into this class, although we think the States have a major responsibility here as well.

A more limited Federal role and increased reliance on the capabilities of local public and private sectors are indicated in the following situations:

Start-up funding for demonstration of new facilities or services which should be time-limited and which should incorporate from the outset feasible take-over financing from permanent alternate sources;

The direct provision of health care to segments of the population whose right to such care is recognized in law or whose need is especially acute because of the failure of more traditional means of providing health services;

The education of health manpower which cannot be accomplished through the basic student assistance programs offered by the Office of Education which are essential to meet especially difficult supply problems with respect to certain professions (e.g. physicians and dentists) or to assure proper geographic distribution of health personnel or demonstrate the role of new types of health workers.

SPECIFIC HEALTH PROGRAM FUNDING

With these principles as guides, we can now examine briefly some of the highlights of the FY 1974 budget.

Total health spending in 1974 proposed in the President's budget for the Department of Health, Education, and Welfare would reach $21.9 billion, $3.5 billion more than our current estimate for 1973, and nearly double the amount spent in 1969. I need hardly point out, however, that a major factor in this increase is the continuing uncontrollable rise in payments under Medicare and Medicaid resulting from expanded coverage, increasing utilization, and inflation in the cost of health care. But we are also proposing significant increases in certain of the controllable portions of the health budget, specifically in cancer and cardiovascular research and consumer protection. Our strategy in the allocation of these controllable funds is aimed, in major part, toward strengthening the Nation's ability to achieve better health without feeding the inflationary spiral that diminishes the value of every dollar we spend.

Biomedical Research.—For the biomedical research activities conducted and sponsored by the National Institutes of Health, we are requesting more than $1.5 billion, nearly $50 million more than our current estimate for 1973. The proposed spending level for research involves substantial increases in the areas of cancer and heart and lung diseases, offset in part by reductions in general untargeted research areas and in research training and general research support and modest reductions made elsewhere in the NIH budget on a priority basis.

The increases requested in these areas will make it possible to support all phases of a carefully outlined research effort in the National Cancer Plan and will permit greater concentration on arteriosclerosis and high blood pressure, as well as continuation of the attack on sickle cell and other blood diseases and on pulmonary ailments.

Research Training—We have, as you know, decided to phase-out research training support. But I want to emphasize that this decision was based on consideration of equity and not on purely financial or budgetary considerations. Specialized support for the training of research investigators over past years has resulted in very significant increases in the number and quality of such personnel and in the capacity to meet future needs. A careful review of this program over the past few years has brought into question the need for and the equity of hundreds of millions of dollars in special Federal support of research training, particularly in the face of large programs for the support of all graduate education already available through the Office of Education. As a general rule, Federal assistance for higher and graduate education will be concentrated on students in financial need. The research training program raises serious equity questions by singling out graduate students in the life sciences as recipients of special Federal subsidies, while graduate students in other physical sciences, engineering, public administration, the arts and humanities and other fields do not benefit from a targeted special Federal program. The phase-out of research training support will eliminate the inequality of special Government subsidies for the support of selected students. This program, as you know, does not target funds on needy or disadvantaged students. Moreover, the income potential of research investigators is such that they should be able to repay loans for educational assistance, as do many other students in advanced training programs.

Health Manpower Training—With regard to support of health manpower training, we have reassessed the need for specialized academic training programs in light of the President's larger commitment to remove financial barriers to college education and recommended that most of the special programs be phased-out. In addition to the training programs administered by the National Institutes of Health, we plan to terminate a number of smaller training support activities funded through the Health Services and Mental Health Administration.

Special Federal support will, however, be retained for training in medicine and dentistry. The relatively more critical role of physicians and dentists in the present health care delivery system, as well as the high cost of their training and the difficulty of expanding the capacity of medical and dental training facilities justify the continuation in 1974 of special Federal intervention to support continuing growths of enrollments and graduates in these fields.

We are, however, recommending the termination of capitation payments for schools of nursing, veterinary medicine, optometry, pharmacy, and podiatry. We also plan termination of the special programs for allied health professions and graduate public health training when the authorizations for these activities expire on June 30. We proposed, however, to expand targeted support for high priority health manpower initiatives and continue significant special project grant awards for both allied health professions development and nurse training.

Our long-range strategy is to use the authority for National Health Service Scholarhsips as our sole vehicle for providing special health scholarship aid to students of the health professions and nursing because the mandatory service provisions built into this program will assist in overcoming the serious maldistribution of health manpower and will help us meet the long-range staffing needs. A legislative proposal to expand this statutory authority will be forwarded to the Congress in the near future.

HSMHA PROGRAMS

Turning to the portion of the health budget administered through the Health Services and Mental Health Administration, certainly the most significant changes reflected in the 1974 budget request are our proposals to terminate the Regional Medical Programs and the Hill-Burton activities and to phase-out support for Community Mental Health Centers.

Hill-Burton.—The Hill-Burton program represents one of the most noteworthy successes in the history of Federal support of health activities. When this program was initiated shortly after World War II, the Nation faced a serious shortage of hospital facilities. Neither the private sector nor State and local government had access to the billions of dollars needed, and a soundly based and adequately funded Federal program was launched and continued for more than a quarter of a century. The Hill-Burton share of hospital and other health facility construction funds has declined from 12.4% in 1962 to 4.4% in 1972. This indicates that to the extent it was designed to encourage the flow of private investment into hospital construction, the Hill-Burton program has accomplished its mission.

We are no longer confronted on a nationwide basis with a shortage of acute inpatient beds. On the contrary, in many parts of the country a surplus of such beds is adding to the rising cost of hospital care. Moreover, more appropriate funding arrangements for hospital construction and modernization are now available, including reimbursement through public and private third-party payment systems for depreciation on capital investments. In 1974, we estimate that Medicare and Medicaid will provide $700 million in reimbursement for such costs and private insurers will provide in excess of $1 billion.

Community Mental Health Centers.—Our decision to phase-out support for community mental health centers is akin to that reached in regard to Hill-Burton. In this instance, however, we think the need to demonstrate the value and effectiveness of innovative community mental health centers has been demonstrated. These centers can and will continue to play a very important part in the management of emotional illness. But Federal assistance has now helped to launch more than 500 centers and the value of these centers has been shown. Now it is time to shift the responsibility for developing and operating such facilities to State and local agencies which must ultimately bear the major responsibility for the direct provision of public health services of all kinds. As the President's fiscal year 1974 budget states, "Critical mental health services will be pro-

vided more equitably on a National basis by financing these services under National Health Insurance."

RMP's.—Initially, the Regional Medical Programs were to have provided an accelerated effort against heart disease, cancer, and stroke. Research discoveries in these areas were to be rapidly translated into improved care for people stricken by these three groups of diseases and related diseases. Those were and are laudable objectives, but the Regional Medical Programs have not made hoped-for progress toward achieving them.

Whereas the initial RMP concept envisioned a limited number of major regional structures, a total of 56 regions have been funded, and the boundaries of 34 of these are coterminous with individual States.

Thus, RMP has directly overlapped and sometimes conflicted with State and area health planning, coordinating, and service programs. There is no clear indication that the Regional Medical Programs have succeeded in getting research advances rapidly into the mainstream of medical practice. The training programs initiated under RMP generally have been of short duration and limited scope; their real effect on medical practice and health care is doubtful.

The demonstration projects funded under RMP grants tend to duplicate HEW and other Federal programs and add to the proliferation of separate projects funded by Federal, State, and local agencies without yielding additional results that justify their continuation. In essence, the Regional Medical Programs have failed to live up to their promise, and their continued claim on the Federal health budget cannnot be defended.

Comprehensive Health Planning and Services.—We are proposing three-year extensions of all but the graduate training authority in Section 314 of the Public Health Service Act. We believe the comprehensive health planning agencies, both State and areawide, are becoming increasingly effective in the development of health systems oriented to their area needs. The budget request for supporting the planning agencies in 1974 is $38 million, $3 million more than in 1973 and $12 million more than in 1972.

The Social Security Amendments enacted last year prohibit Medicare and Medicaid reimbursement of costs related to capital expenditures by a health facility which has made capital improvements against the advice of the comprehensive health planning organizations. This new responsibility will be a major test for these agencies. Therefore, we are proposing a three-year extension so that we may thoroughly evaluate CHP to see if it can effectively carry out this new responsibility. We are hopeful that increasing the authority of the CHP agencies will lead to a more rational pattern of development in State and local health resources and contribute to the future fiscal independence of the planning agencies. In the long term, the health planning process is a State and local responsibility, and the present program must prove its value to health providers, consumers, insurance carriers and State and local government.

Famliy Planning.—We propose continuation of the present family planning project grant activities, including projects formerly supported by the Office of Economic Opportunity. These activities would be supported under the general authority of Section 314(e) of the PHS Act, rather than continued as a separate categorical authorization under Title X of the Act.

Migrant Health and Neighborhood Health Centers.—Another authority now categorically separated in the statute would also be funded under the general provisions of Section 314(e). We propose to continue to improve our migrant health activity but that an extension of the present categorical support in Section 310 of the PHS Act would be duplicative and unnecessary.

Our neighborhood health centers program—along with that transferred from OEO—will also continue to be carried out pursuant to Section 314(e).

Other Authorities to be Extended.—We have transmitted to the Congress our proposals to extend permanently without change, the authorities contained in Sections 304 and 305 of the PHS Act, relating to health services research and development and health statistics, as well as a proposal to continue the medical library authorities. We also support the folding of the special project grants for maternal and child health purposes into the State formula grants after June 30 of this year, as provided by law.

Drug Abuse and Alcoholism.—The activities under the general leadership of the Special Action Office on Drug Abuse Prevention will be expanded in 1973 and maintained in 1974. There were 145 projects underway in 1972. In 1973 we expect to have started 191 new projects. Evidence so far available indicates that this effort is having a very significant impact on drug addiction. Our data indicates

that up to 50 percent of drug addicts will volunteer for treatment if adequate services are available, including detoxification, methadone maintenance, rehabilitation and after care services. Currently, drug abuse continues to be a special case of Federal concern. There is, however, adequate substantive authority to respond to the problems in other laws, notably, the Drug Abuse Office and Treatment Act of 1972. We have already transmitted to the Congress a request to increase the authorization level of Section 410 of this Act to provide for these activities.

Because of the rapid buildup in recent years, the Department's alcoholism program now funds 469 projects in communities across the Nation. These projects have gone a long way toward creating the kind of national awareness needed to overcome the problem of alcoholism and they will be maintained in 1974. Our project grants have pointed the way and created a substantial new capacity but the real test will occur at the local level. We believe that the results of the Federally-funded projects can now be integrated with expanded community efforts. Therefore, we propose to phaseout project grants to the States.

Mr. Chairman, I have not tried to make a comprehensive presentation of the 1974 health budget. But I want to conclude by focusing on a basic policy issue.

For many years, people have been led to believe that if a problem exists in our society—be it poverty, lack of educational opportunity, or lack of health care—the solution was to set in motion a massive Federal program to fill the need. Obviously, as we have recognized, there have been and will continue to be instances where nothing short of direct Federal intervention will suffice. But to assume that the Federal Government must become the solution of first resort, rather than last, is to determine in advance that other public and private institutions and social structures are hopeless failures that can never be expected to serve the American people adequately and equitably. We simply cannot accept that untested conclusion. Moreover, we believe that the proper Federal role, in health as in many other areas, is one of support, not domination. In the long run, the Federal role is one of assuring that the financial barriers to health care are eliminated. Our proposal for national health insurance will be designed to do this.

The FY 1974 health budget is predicated on the concept that our health systems must be supported and strengthened by Federal dollars, not controlled by them. Our purpose is to enable public agencies at the State and local level to discharge their necessary responsibilities and to assure that private initiative and resourcefulness are given the oportunity to serve the health needs of the vast majority of Americans at competitive prices wherever possible.

We must now move beyond the kind of thinking that says Federal dollars are the best or the only way to solve problems. Experience has shown that this too often is not true. Moreover, we have learned that Federal spending programs can sometimes create as many new problems as those they are created to solve.

The 1974 health budget is a major start toward breaking out of the rigid and outmoded patterns of the past. We intend to match this initiative by making needed changes in the way the Department organizes and administers vast health enterprises. I am now in the process of restructuring the Office of the Assistant Secretary for Health, and we intend to pursue other opportunities to improve the management of the Department's health enterprise.

Mr. Chairman, we have not taken lightly the policies which guided the formulation of this budget request. Neither do we assume that the changes we are suggesting will yield instant solutions for problems, some of which have been with us for many years. But we believe that the time for fundamental changes has long since arrived.

Now if my colleagues and I can answer any questions the Subcommittee may have, we will be pleased to do so.

Chairman HUMPHREY. All right, Dr. Edwards. The material that you have in the last half of your prepared statement relates to specific budget items, as I understand, is that not correct?

Dr. EDWARDS. That is correct.

Chairman HUMPHREY. Well, Dr. Edwards, I am sure you are fully aware of the testimony of the prestigious Association of American Medical Colleges.

Dr. EDWARDS. I have not seen the testimony, but I am aware of the fact that Dr. Cooper did testify before you yesterday, yes, sir.

Chairman HUMPHREY. That organization represents most of the medical schools, I think, in the United States.

Dr. EDWARDS. That is correct.

Chairman HUMPHREY. 114 operational U.S. medical schools and their students, 400 major teaching hospitals and 51 major academic societies whose members are engaged in medical education research.

I noticed your last figure, which is becoming rather commonplace in the description of the President's budget, that you are spending more now than you did before. It is an interesting thing. On the one hand, the Congress is accused of wildcat spending, and on the other hand, the administration says, we are the economizers; yet every time we face the administration witnesses, they always tell us that they are spending more than they ever spent before. They kind of like it both ways. You know, the public is led to believe that the Congress is an irresponsible bunch of spendthrifts. That is the propaganda kit that your agencies and others have, which I have examined in great length—which by the way is a kit that is in violation of public law, according to the General Accounting Office, and I have submitted it to the Justice Department if they find any time to take a look at it and see what they can do about it.

Now, you say here that the total proposed spending in 1974 would reach $21.9 billion, $3.5 billion more than our current estimate for 1973 and nearly double the amount spent in 1969.

I just want to make the point once again that it is hard for me to understand how the administration can claim that it is the great economizer on the one hand, Congress is the great spender on the other hand, and every time we get a representative of the Department before us, they show us that they are spending more than they ever spent before. It is a good argument, a good debate point.

How much of that figure $21.9 billion is medicare and medicaid?

Dr. EDWARDS. I think between $17 and $18 billion, Mr. Chairman.

Chairman HUMPHREY. Would you get the exact figures?

Dr. EDWARDS. I think it is $17,357 million.

Chairman HUMPHREY. For medicare and medicaid?

Dr. EDWARDS. Right.

Chairman HUMPHREY. How much of an increase is that over fiscal 1973?

Dr. EDWARDS. Approximately $3 billion.

Chairman HUMPHREY. So that the real truth is, then, that with the exception of medicare, if you take medicare and medicaid out, you really do not have much of an increase—how much would you say? $500 million increase?

Dr. EDWARDS. The major increase, Mr. Chairman, is about $500 million and that primarily is in the direction of the cancer program and the heart, cardiovascular.

Chairman HUMPHREY. And community medical health centers are included in that?

Dr. EDWARDS. That is correct, yes, sir.

Chairman HUMPHREY. And that figure is for 8 years instead of 1, the phaseout figure?

Dr. EDWARDS. Yes.

Chairman HUMPHREY. What is that figure?

Dr. EDWARDS. It is around $600, as I recall—in the vicinity of $600 million.

Chairman HUMPHREY. So that figure ought not to be included as a part of the annual budget for medical care and medical research and medical services, because that is an 8-year phaseout figure. Is that not correct?

Dr. ZAPP. Yes.

Well, Mr. Chairman, in some cases, there are some community mental health centers that would have been approved in the last year.

Chairman HUMPHREY. I know, but what is the figure for community mental health there?

Dr. ZAPP. Mr. Chairman, I am just attempting to get the exact figures that you are requesting, because it is a buy-out pass fiscal 1974 that you want.

Yes, sir, we have that figure around here someplace.

Chairman HUMPHREY. The staff will find that figure for us.

The authorization for request for budget authority is $636 million.

Dr. EDWARDS. Thank you.

Chairman HUMPHREY. So that is for the 7-year period, the phaseout.

Dr. EDWARDS. Correct.

Chairman HUMPHREY. So if you would phase that out, let us give you credit for the first year of about, at least $150 million. That would be a pretty generous request. So you really do not have any extra money at all in the budget. You really do not have any. Is that not a fact, now, Dr. Edwards?

Dr. EDWARDS. I think it certainly is a fact that we have had to, with the exception of the President's desire to keep within $250 billion——

Chairman HUMPHREY. No, I am talking about fiscal 1974, when you want $268 billion.

Dr. EDWARDS. No, you are correct in the figure, that I think around $100 would be approximately correct.

Chairman HUMPHREY. So there really is not any new money in there at all, any additional funds.

Now, the increase in costs on medicare and medicaid is $3 billion. That is really rather an uncontrollable item?

Dr. EDWARDS. That is uncontrollable, right.

Chairman HUMPHREY. And the total sum of new money you would have over and above last year is about $500 million. And fiscal 1974, which includes $636 million for an 8-year phaseout of community mental health, I give you credit for $150 million because I want to be generous. You really would not spend that much in community mental health? One year in an 8-year phaseout. So you really do not have any extra money, and you have not taken into consideration the inflationary costs which are, in some areas, very, very high. These general figures do not really sometimes satisfy the realities of life.

Now, I know that you have to live within the confines of the OMB, but I am weary of this budget mathematics. I think the American people are entitled to the truth. If we are not going to spend more, we ought to say so. If we are spending more, we ought to say so. And what we are doing, we ought to say so.

Now, the budget is an annual budget. That is what we are concerned about and we have to give annual figures and the fact of the matter is that the budget for fiscal 1974 in terms of dollars—not purchasing power, but just dollars—for the fiscal year is less than the budget of

fiscal 1973 if you exclude the items of medicare and medicaid, which are uncontrollables, which are draws on the Treasury by the nature of the law.

Is that not a factual statement, Doctor?

Dr. Edwards. I cannot say necessarily that it is less, but there are certainly no increases in the budget.

Chairman Humphrey. I think that is one of the points that we need to clear up here. Now, there may be a reason for it. I do not happen to think that expenditures on health care are exactly the major item in inflation. You know, every time we have testimony, we hear that this is one of the ways we attack inflation. I think one of the ways to attack inflation is to keep people well so they are at work, and to trim the budget on health care is not a way that you help the consumer.

Let me ask you this—go ahead, please, sir.

Dr. Edwards. I was going to say, Mr. Chairman, that in principle I agree with you, but I think one of the issues that we have to realistically face is that over the last decade, let us say, in spite of tremendously increasing expenditures by the Federal Government in the field of health and biomedical research and so forth, we have to recognize a couple of things—No. 1, the delivery of health care services is no better today than it was 10 years ago. We have not solved that problem. The manpower problem is every bit as bad today as it was 10 years ago. In other words, Dr. Cooper and his associates have not solved our problem in spite of the fact that we have thrown him billions of dollars more each year into their operation.

I think the cost factor has continually gone up. We have not solved that problem.

The point that I am making is that in spite of the increased expenditures, the fact of the matter is that we have not solved the problem, we have not developed adequately any Federal health strategy.

Chairman Humphrey. That is correct.

Dr. Edwards. We have had a lot here and a lot here, with no real priorities developed in how are we going to accomplish, get to the end of the line. These are issues that some of us are trying to come to grips with.

Chairman Humphrey. I know you are, Doctor, and I do not mean to be personal at all in my comment because I know of your professional competence and your desire to help improve the health care system. And you have put your finger on something three of the witnesses said yesterday and something I have been working on all my life, that the organization of the health care system in this country is obsolete. It is scattered and there is no relationship between the professional needs in the health care system and the services that are delivered. Doctors do not need to do half the things that they are doing today. We know that there are paramedics that can be used or paraprofessionals. The time that doctors spend with many of their patients could be limited and many of those needs could be fulfilled by others.

Again, my point is that this budget, as other budgets, does not really come to grips with the structural organization of the health care delivery system. In the meantime, what worries me more than anything else, and I have to speak very bluntly about it, is that when you start to trim back on the trainee programs, when you start to trim back on the programs that the director or the head of the University of Minne-

sota medical school talked to me about—we have one of the great medical schools in the country, and he came to me and said, Senator, I can tell you that the Government is going to cripple this medical school, not today but for years to come, because really the health personnel that we need is being educated now. When you start to cut back on these graduate fellowships, these trainee programs, that simply means that the people that we need to be the teachers and the experts for years to come are not going to be there.

I am worried that even now, as we try to hold this budget for fiscal 1974 in line as you have indicated, that what we are doing is robbing Peter to pay Paul. We are at the present time easing it up only to have more problems on our back down the road.

Now, I was home when my mother passed away a week ago and while I was there, the Sisters of Saint Johns Nursing Home in a small town came to me and said, Senator, we are going to have to close the nursing school—it is not a nursing home, it is a nursing school, an accredited school, a fine school. They said, we cannot get teachers. Now, we are short of master's degree teachers in nursing.

I go to the University of Minnesota and I want to talk about what I know about it. I do not claim to be an expert in this, but I sure do know the university. I have been a professor there and I have met with all the faculty members, the deans, I should say, and the heads of the departments. I spent 1 full day with Dr. Malcolm Moos and all his department heads on this budget. I know that if the budget goes through the way it is, not being altered by the Congress, we are going to have serious difficulties in our nursing schools, our dental schools, and our medical schools and in our pharmacy schools. These are all related to health services, but the three schools in particular, medicine, dentistry and nursing. Now, you can probably get by this year, but every year that we lose preparing those people for future service is time lost and services never to be recovered.

I am deeply concerned when I read the statement of Dr. Cooper yesterday, whom I respect—and I am sure you do; I am sure you know him. I do not think he is guilty of demagoguery and I do think that he and his associates have looked at what they consider to be the health needs of this country. That was a very moving statement. And when he points out that Federal funds available for support of programs in research, teaching, and service will drop 11 percent from the fiscal 1972 level and more than 15 percent from the level in the current fiscal year, and 26 percent from the level planned by the schools in fiscal 1974, I say that that is a serious matter. And I do not think that you can have a health service program unless there is cooperation between the medical schools on the one hand and the Federal Department of HEW on the other, in your division.

You cannot plan. How are you going to plan medical education unless we can plan on what the Federal Government is going to do? You just pull the skids right out from underneath them. I think Dr. Cooper's testimony has to be responded to. Is he telling the truth or is he not?

Dr. Edwards. Mr. Chairman, let me just say that I have not seen Dr. Cooper's testimony, but let me made several observations.

First of all, I completely share with you the absolute need for the Federal Government, those of us in the health field in the Federal Gov-

ernment, to work very closely with he responsible organizations within the health care system. There is no question about that. But I think we also have to recognize that we have created in this country a system of medical education that is so far more expensive than any other kind of education that they are beginning to price themselves out of the market. I think Dr. Cooper and his colleagues have to lay all of the cards out on the table just like we in the Federal Government have to lay all our cards out on the table.

For example, you talk about the research training grants. I, like you, am deeply concerned that we not overkill in the case of research training grants. But anyone who knows will have to be frank to say that research training grants have been badly abused and misused by the medical schools, the medical centers of this country. So when you say we have to work together, we do have to work together, but we all have to work together honestly and with all of the cards on the table.

I have great respect for Dr. Cooper and certainly for the Association of American Medical Colleges, but they have to be honest, too, that there is an awful lot of fat in the budgets of most of the medical schools through research training grants and the like. I think what we are trying to do—and again, as you point out, we have to avoid overkill here—but we have to have them recognize, too, that there is a limit to what the Federal Government can do in terms of financing and so forth.

Chairman Humphrey. I would not disagree. There obviously must be some limits. I do not know what that would be. But what I am getting at, I so much agree with you that the health care system is so disorganized. But what bothers me is that the Department of HEW, as you have indicated, puts in a substantial amount of money into the American health care system, really is not coordinating with the medical schools of this country and the training establishments. Because it is perfectly obvious that the men I have talked to, and they have been to see me by the dozens and I have here in my hand documentation from a splendid school of medicine, school of dentistry, school of public health—we have one of the large public health schools in the Nation, 1 of 10—they were not consulted in this budget. How in the devil are we going to have organization of the health care delivery system in the country if you have in Washington or we here in Washington are working on our wavelength and never talking to the people out there that are preparing the technicians and the professionals?

That is the problem with this cockeyed budget. It is prepared in the catacombs or the cocoons of the OMB. They do not talk to anybody. They really do not. They may talk to you, Doctor, and I hope you have time to talk to all the folks out home. But I asked Dr. Malcolm Moos, who was Dwight Eisenhower's assistant down here and is an extraordinarily able man, I asked every one of the deans of these schools, and I have them all here, their statements, did any of you ever have any consultation with anybody from the Office of Management and Budget? To a person, man and woman, they said, we never saw them; nobody ever talked to us.

Now, how are we going to have an organized medical care system if we never talk to each other? Do you have a system where you really

build this all together? Were your recommendations, Doctor, for the health care of this country agreed to by OMB?

Dr. Edwards. Mr. Chairman, let me say I was not around at the time that this budget was developed.

Chairman Humphrey. Well, I hope that since we have so many wiretaps these days, somebody knew what your predecessor was doing. I am really kind of fed up with the fact that we cannot get information.

Did your predecessor have something to do with the preparation of this budget?

Dr. Edwards. He did, but I think here again, not only is the health care system disorganized on the outside, but it has been disorganized on the inside as well, as you have said, you and I have mentioned earlier this morning. I think that one of the reasons that the health establishment did not have the kind of input into the 1974 budget that they perhaps should have had is not the fault just of the Office of Management and Budget, but I think it is probably the fault of the Department of Health, Education, and Welfare and the lack of coordination perhaps that we provided. This is one of the things we are trying to come to grips with, but it is a tough one.

Chairman Humphrey. What is your plan for the immediate future to bring this disarray into some order?

Dr. Edwards. One of the problems over the years has been that each of the health agencies in the Department of Health, Education, and Welfare has spoken as their own autonomous groups. The National Institutes of Health has spoken for the National Institutes of Health. The Health Services for Mental Health has never bothered to speak to anybody else; the FDA goes its own way. When Mr. Weinberger asked me if I would take this job, I said I would take the job if he really wanted somebody to come in and speak for the health establishment as though we spoke with one voice, that we used these priorities to in fact influence our own spending. This is what we are trying to do. We now have line control and management responsibility over all the agencies. We are not trying to interfere with their day-to-day operations, but we are certainly going to interfere with their development of their budget—not interfere, but get involved in it. One of the first things we have done is to reorganize the whole Health Services and Mental Health Administration. This was an organization that spent some $2 billion a year, it had some 27,000 people, and nobody really knew what it was supposed to do. We are reorganizing it——

Chairman Humphrey. I do not really believe that is a factual statement, Doctor, as much as I respect you. I know a good deal of what goes on in mental health activities.

Dr. Edwards. I did not say mental health alone, but it was a new unit made up of many, many, and they had no specific purpose. They had lots of groups, but we are trying to break it down so the National Institutes of Mental Health operate as a manageable unit, not such a large unit that it is not manageable.

I did not mean to reflect on the National Institutes of Mental Health. They have done some outstanding things.

Anyway, I think this has to be brought about by some mechanism in order to begin to talk as a voice and try to develop a system that will develop some kind of a Federal health strategy and not this hit-and-miss effort that we have been witnessing over the last 25 years.

Chairman HUMPHREY. I want to come back to you, Dr. Edwards, because I know you have some ideas on this. I want to talk them out with you, but Representative Brown has been kind enough to join us in this subcommittee this morning. He is an active member of this committee and I know he has some questions. He has to leave very shortly.

Representative BROWN. Dr. Edwards, I am sorry, I have an appointment in my office at 11:30 with some people who want to talk to me about the problems of the Federal Government's relationship with medicine. They are from my constituency and district, and I feel that that may take precedence over this concern.

The total budget since 1969 in the health area, what has happened to it?

Dr. EDWARDS. It has gone up considerably. I can give you the figures. It has approximately doubled. I do not have the exact figures, but it is for all practical purposes about double.

Representative BROWN. Is that an equation that has been going on for some time?

Dr. EDWARDS. Oh, I think it has been over the last—since 1962, 1963, 1964, in that general area. I cannot give you the exact dates—probably 1965.

Representative BROWN. Can you get us a current dollar value?

Dr. EDWARDS. The total health budget, as I mentioned, is approximately $22 billion.

Representative BROWN. All right. The current budget total, which is staying the same in 1974 as in 1973, if I understand the exchange you had with Senator Humphrey——

Dr. EDWARDS. That is approximately right.

Representative BROWN [continuing]. Provides for some programs to be increased, some to be decreased, and some programs to stay about the same, is that correct?

Dr. EDWARDS. That is correct.

Representative BROWN. So what is going on, I guess, is a process winnowing out programs that you feel are not particularly worthy and trying to enhance those programs that had been beneficial?

Dr. EDWARDS. That was the thinking behind the current budget. Now, you may argue how some of these resources were allocated in that process, but nevertheless, that was the thinking.

Representative BROWN. Let me go back to the question of the increase. Let us assume that this budget has been doubling every 4 years for the last 10 years. Has the delivery of medical services or the definable improvement in medical services also doubled? In other words, what is the relationship to the increase in the expenditure of money? What are we getting with the doubling of budget over the last 4 years?

Dr. EDWARDS. I think that goes to something Senator Humphrey and I mentioned earlier. I think that is the gut issue. We have to begin to think in terms of cost effectiveness in health care. For some reason or other, there are some, particularly many medical educators, who feel that we are above and beyond getting involved in a cost effectiveness kind of thinking. The fact of the matter is that there has not been any cost effectiveness as a result of which, although we have continued to pour these increased millions of dollars into the system, the problems

of the system are probably as great today as they were in 1965, maybe worse.

Representative Brown. Let us talk about cost effectiveness, for instance, in research and training grants for the minute, because we are considering legislation before the Interstate and Foreign Commerce Committee in the House, which I am on and I have two grave areas of concern. One is the question of conversion of Federal grant moneys from research activities to administrative costs when they go to medical schools and other research programs that the Federal Government helps finance. Now, I get the distinct impression from people I have talked to that that not only occurs, but it is one of the things that some institutions tend to survive on, that their allocation of costs in grant programs is quite high in the area of general administration, and that the research results we are getting may be sometimes fairly limited. Can you put a percentage on that kind of thing?

Dr. Edwards. I cannot put a percentage. I can certainly agree with you, though, that this whole research training grant, research training grants generally have been, as I mentioned earlier, misused and abused. The medical schools of this country have never really looked hard and long at the problem of trying to economize. There are medical schools that have four and five electron microscopes around where one might do the job and the four or five are only used maybe 1 day a week and so forth. I mean they have lived in a world in which they have been able to have the best of all worlds and I think they have, like the Federal Government, we have some things that we have to do, too, but nevertheless, we have to bring them into the real world, too.

Representative Brown. Would we be more honest with the taxpayer, who is one of our concerns, I trust, as well as the consumer, because he winds up being both—he pays and he gets out of the Federal Government, and sometimes he pays a lot more than he gets and sometimes he gets more than he pays and perhaps considers himself lucky—or maybe it is an accident. But at any rate, would we not be more honest if we said we want to support medical schools, equip them, fund them, help pay their administrative costs and subsidize the education of doctors, if we just simply put that money into that program and then put research and training money into areas that were specifically research and training? Is there any way we can get to that kind of definition of the use of Federal funds?

Dr. Edwards. I think you are talking about general institutional support versus the categorical kinds of support that we have tended to do in the past. Am I correct?

Representative Brown. Sure. I am thinking of things like the "conquer cancer" legislation that we passed last year. I hate to be cynical, but the thing I wonder is how much of the conquer cancer money will wind up in research on cancer and how much of it will wind up in paying for the enhancement of maternity wards at somebody's hospital by that subtle conversion of funds from the administration of the cancer research into the administration of the general hospital services, or the medical school library in fields other than cancer research.

Dr. Edwards. Your question is a good one. One of the problems is I do not think we can even answer the question.

Mr. Altman. About a year ago, our office started a fairly elaborate, about a 2- or 3-year study, just aimed at this, called the black box study, because our problem has been that money flows into medical schools from a whole variety of sources and comes out from another whole variety of sources, and it has never been clear to us through what channels. It almost does not matter what channels. It goes in under research funds and comes out under patient care. We have gotten very, very good support from the AAMC on this. The medical schools also admit that they do not know where the money goes.

We have had a contract now, I think for about a year, with the Rand Corp.—I think it has about 6 more months to go—to try to find out if we can link up the resources with the uses. When we get that study completed, we will send it along to you.

Representative Brown. It is not that I think that somehow there is a suggestion that there is more worthiness in subsidizing the education of doctors than there is, for instance, in the subsidization of research but rather, when you start carving up programs, cutting down on one and enhancing another because it seems to be more desirable from the standpoint of what the future Federal attitude is, the attitude about Federal programing in medicine, but this winds up going back to a hospital or institution someplace where the actual use of that money might not be in the same proportion or same focus of priority that the Federal Government had in mind in the first place. I also feel concern about one other area, and that is in the research field, whether or not the grant of Federal funds by either a single administrator or a single board does not tend to make us in the research area trend toward only the school solution or the Federal, the current Federal fad in solving some medical problems. I have a feeling that maybe with all this money that the Federal Government is putting into cancer, we will direct research in cancer in areas that may or may not be productive. They could just as well be unprovocative if there is a single attitude on the part of those people who are distributing Federal funds.

Is that an area of concern, Dr. Edwards?

Dr. Edwards. It is a very real area of concern. I think one of the things we have to do is maintain the strength of the National Institutes of Health. It is an international resource, and I think we have to maintain it as that. But in order to do that, we have to be careful that we do not target so much money that we lose the balance between the programs out there. We need appropriate sums of money in cancer; we need appropriate sums of money all the way across the board in all the things out there.

We have to have a system that is flexible enough to allow us to target on certainly priority areas, but not at the expense of doing away with other important programs now. We have to be careful in programs like cancer that we do not overfund cancer and underfund something else. This is a very extensive balance and one that I was not as aware of until I took over this job, but it has to be maintained.

Representative Brown. I have in mind the live virus polio vaccine solution which is currently used generally as against the Salk method. And while I understand both studies were federally funded to some degree, I heard Dr. Sabin relate the fact that he had some freedom to

get into an area that he thought deserved more attention because he had some private funds to work with. I am just a little concerned that maybe we go just in one direction.

I have one final question, with the chairman's sufferance.

Chairman HUMPHREY. Go ahead.

Representative BROWN. That is, if you would break out the details in the hospital costs increasing at the rate of 12.8 percent. Do you have a detailed breakdown there? I would like to know why hospital costs are so much higher. Now, there are a number of possibilities that occur to me. One is that hospital care is a labor intensive business, more so than others. Are labor costs a significant percentage of the 12.8 percent, or are we receiving more sophisticated medical care in terms of the machinery that is attached to the patient and therefore has to be financed by the hospital?

Mr. ALTMAN. Yes. In the 1971–72 period, the expenses per patient day——

Representative BROWN. That is 11.6 percent in the figures you have given here.

Mr. ALTMAN. That is right. Of that, 5.7 percent were due to increases in wages and prices. This is due to buying the same amount of labor and the same amount of material, but just the increased general price levels.

Representative BROWN. You are talking now about the custodian that comes in and washes the floor in the patient's room, the same kind of qualifications, the same kind of service that was provided?

Mr. ALTMAN. That is right.

Representative BROWN. That has gone up how much?

Mr. ALTMAN. 5.7 percent of the 11.6, or less than 50 percent of the 11.6, was due to wage increases and price increases for the same service. A little over 50 percent was due to improvements in or changes in service—more labor and more capital. The major increase was due to more capital; 10.1 percent increase—this includes new plant and equipment. New machinery, different types of machinery. So over 50 percent of that 11.6 was not due to wage or price increases.

Representative BROWN. So you are saying that in fact there was a better delivery of health service for which the patient is paying an additional fee?

Mr. ALTMAN. In some sense, it is. The problem we have and the problem everyone has is to differentiate in that 50 percent how much of it was due to the fact that this industry has been a cost-plus industry, where someone sits behind them with essentially a blank check, providing funds for new equipment. Now, it is a very difficult thing to decide how much of that increase was marginal at best in terms of improved medical care. We have a feeling, and so do most experts that have looked at this problem, that there is a significant amount of so-called fat. That is one of the areas that has been pared down.

Dr. EDWARDS. We have really never developed in the system any way of controlling the urge for every institution in a particular city to want to have their own renal dialysis unit and their own cardiac surgery unit, and so forth. All of these are reflected in this figure that Mr. Altman gave you. Some way or another, we have to come to grips with that problem as well.

Mr. ALTMAN. I think it is a terribly telling figure that if one looks back one step to the period just before the economic freeze, when ex-

penses per patient day were going up by almost 15 percent—14.8—6.6 of that was due to these changes in new equipment and more hiring. One often hears the fact that this industry's rising costs are simply due to the fact that we have introduced minimum wage laws or had to raise the level. That is just not true.

Representative Brown. It actually is the increase of services that the patient is getting that contributes a great deal.

Mr. Altman. Well, it is increased manpower and increased equipment. Whether it all comes in the form of increased services is another question.

Representative Brown. One final thought. This is not a question, I guess, just an observation. It seems to me if the Federal Government is to impose rather tight controls on that increase in costs in the way of phase III guidelines, there is some dichotomy, although perhaps a justifiable one, in the Federal Government doing other than maintaining its own spending level in this field. In other words, to say to the hospital out in the field, you cannot increase your expenditures and costs, but we will at the Federal level, does provide some contradiction.

Mr. Altman. I think we have tried to be consistent, and I guess that is some of the criticism at us. We have also said to ourselves, we cannot spend as much. As Dr. Edwards has been outlining, we have tried to impose on ourselves the same frugality that we are asking the hospitals to impose.

Dr. Edwards. Really, one of the current issues that might be of interest to both you and Senator Humphrey is under H.R. 1, I mentioned the kidney dialysis program. We are trying to develop criteria right now under which a patient will get treatment under H.R. 1 for kidney dialysis. This is where the Federal Government has got to get into the organization of health care services and has to take—if we do not get into it, this will totally run out of control in terms of costs and poor practices, cost and quality. We are developing now, and hopefully will have them in the week, specific criteria under which a patient can get treatment, where he can get treatment and so forth, under H.R. 1, the kidney program. We have to do more of this as we move along.

Representative Brown. In fact, in Pennsylvania, I heard as we were driving back after the Easter recess, Governor Shapp has proposed that hospitals be made licensed institutions under some State law, with the idea that they are controlled by a board of supervisors not unlike a State board of regents for the universities, and that that board then determine who gets the kidney dialysis machine in a certain community. Hospitals would therefore not compete and, in effect, they would fall into the category of public utilities to be run with all the efficiencies with which we run other public utilities from the Federal and State level, through the ICC, and in the case of Ohio, the PUCO. If that happens to medical facilities in this country, I suppose we will be making an even greater Federal contribution, because we are in that business with the railroads currently. I am not sure that carried to its ultimate conclusion, that is a very desirable direction for medicine to be heading.

On the other hand, I buy your point, Dr. Edwards, that it does not make too much sense if every little county hospital has its own dialysis machine that is only used every couple of years.

Dr. Edwards. I do not know exactly what the system is going to look like, but I do know that the hospital manager is probably the only manager in the American system who reports to two groups, neither of which knows anything about what he is doing. The hospital medical staff are not sophisticated in terms of management principles and economics and so forth, and the board of trustees in most hospitals are business leaders that know nothing about the hospital health care situation. So we have to build into the system some kind of an organizational structure that can look at the issues that we are talking about right now and provide some kind of regional oversight to avoid some of these duplications.

Representative Brown. Mr. Chairman, if you will excuse me, I will let you and Dr. Edwards work that out here, and I will go back to my office and work it out for Ohio.

Chairman Humphrey. I think the line of questioning is very helpful. Thank you, Congressman Brown.

I'll just add my word to this. I am familiar with some of the duplication of equipment and services that you are addressing yourself to. I think it is a matter of great concern because there is an overexpenditure at times on these facilities, and particularly this equipment. Every hospital—not every, but many of them in the community—have the facilities that go relatively unused because they are the kind of equipment that is not called upon too often. I recall some time ago being up here in New York at a hospital where I was privileged to speak, and my research people dug out the number of cardiac units that were available in that immediate vicinity and how seldom some of them were really needed, and with better organization, you would have gotten greater use. In other words, you would have had your cost-benefit ratio, to use the terminology here, much better.

I think this is the kind of organizational work, Doctor, that is needed, and I have the feeling that on this area, we are in complete agreement. What bothers me is that I do not see the structural organization yet that is going to bring this about. People in the Federal Government have stood in fear of the American Medical Association, of the Hospital Association, and other associations, lest it interfere with their complete independence of activity. Yet the Federal Government is now getting into this medical care business with billions and billions of dollars, and the time has arrived when we have to set up some kind of management facility at the State and Federal and local level, with some kind of cooperation with the private institutions, that makes some sense.

My question is not now in the form of critical interrogation, but rather in terms of information. What are you doing or what do you have in mind that you think will improve the type of coordination that is needed or bring about the kind of coordination that is needed?

Dr. Edwards. Well, Senator, I think probably the really big test for the Federal Government in the health care system right now is the Professional Standards Review Organization, which the Congress passed just a year ago.

Chairman Humphrey. Yes.

Dr. Edwards. I think whether we can pull this one off or not is really going to determine our future or the future role in organizing and having some input into the health care system. As you know, this

is the first time that a quality control mechanism has been or is being developed to try to assure, one, that the patient gets the quality and kinds of medical services that he needs, and that we do not overutilize medical services. As you know, the pressure is on us on this one by outside organizations, many of whom you have just mentioned, and are very, very significant. Whether we can pull this one off, I think make it is a workable system, is probably the biggest single test we have going today.

I think there are a number of other efforts that I think will bring some organization and sense into the health care system. I think the whole HMO effort——

Chairman HUMPHREY. That is correct.

Dr. EDWARDS. I think that is going to help.

Chairman HUMPHREY. I think that offers a real opportunity to build a base of structural organization at the consumer and at the delivery level, so to speak.

Dr. EDWARDS. Right.

Chairman HUMPHREY. There is no question about that, and I think that is another big, big test. I think in the next year or two, to really make comprehensive health planning a meaningful activity and not just an organizational framework in the States and the local areas, really make it a working operation, I think is another major challenge we have.

I think there are a number of other areas, but I think those certainly are three that are most significant and can probably have as much impact over the next few years as anything I can think about.

These are going to be the real test cases that you are talking about right now.

Dr. EDWARDS. Absolutely.

Chairman HUMPHREY. Yesterday, in the Senate, we passed, as you know, a bill to establish a commission on the study of health care delivery systems. I am always somewhat worried about commissions, but at least, we are going to try to make some effort at it. I think this is vital. But you are the assistant secretary for the medical programs today and I gather that Mr. Weinberger asked you to take on this task because there is a need of pulling these many facets of our total Federal involvement in medical care and health care, pull them together. But again, my point is I do not think it does much good to pull them together here in Washington unless we are pulling them with the folks out where they really live.

Now, there have been some people here, but not 210 million of them. I have a peculiar interest in this as a long time—I was once chairman of the Health Subcommittee of the Senate. I was for 10 years on the Science and Research Subcommittee of the Senate. I worked for years in information retrieval. I have traveled the world over looking at hospital and medical systems. In fact, that is where I ended up with Mr. Khrushchev in 1958, when I was there visiting with him, in the Soviet Union studying their medical system. I just came back from studying the system in Poland—not that I want to buy their system, but I want to know what they are doing. I was particularly interested in what they are doing in rural health care.

I want to say again looking at the budget, and I am now talking to you as an interested citizen as well as a Senator, I do not really see

where the budget for fiscal 1974, which you did not prepare personally but you are responsible now for it, where that budget gets at some of the problems we are talking about. Just to cutback on money is one thing. I mean, you can say, well, the colleges of medicine are expensive. Of course they are. They are about twice as expensive in terms of labor intensity as an industry—a little over 2 to 1—because so much goes into personnel.

You can say, as was said here, that a lot of these research grants go for administrative costs. Well, you cannot run a research program without some administrative costs.

I have been for years closely associated with the University of Minnesota medical school. I established the first polio research foundation of any city in the United States or any community when I was mayor of Minneapolis. We had a major epidemic of polio. You will recall Sister Kenney was in our city. I had 1,700 cases of them, mothers bringing their babies to my doorstep when I was mayor of that city. I opened up Fort Snelling barracks, two schools, and made them into hospitals.

I went through the troubles of some of what we call the funding of these programs. I had the unique privilege of being the original introducer of medicare. I realize it has limitations. My mother had medicare, and I want to tell you something. Without medicare, that little business that our family had would have been dissolved and we would have been bankrupt. Medicare was a godsend. I do not care if you do make some mistakes, you could not make half as many mistakes in medical care as you do on one battleship; not one. I am unimpressed about hearing about mistakes on these medical programs when I know we are experts on mistakes down here. We pull some real mazuzas.

That gets me down to a little question here. I am going back to these medical colleges, because I think that is where we have to look to the future, both in terms of cooperation between the Federal Government and the practitioners of health care—not just medical colleges. I mean the whole spectrum of the life sciences, right across the board. And now we have many interdisciplinary activities in these universities and these great health centers.

For example, is not this budget devoid of any funds for construction facilities?

Dr. Edwards. That is correct.

Chairman Humphrey. Now, why? I mean, really, why? How can we afford to build some building here in Washington but we cannot afford to build a medical school? Why can we afford, as I saw the other day, to give Litton $182 million advance loan with no interest to build some destroyers, but we cannot build a hospital or a medical school to provide for doctors?

I just do not understand the priorities, Doctor, and I am going to keep hollering about this until somebody does something about it.

Dr. Edwards. I certainly would not want to speak to Litton, but I would attempt to—again, we have to achieve some balance in this. Medical schools are underutilizing some of their resources and we have to have sufficient impact, and this is what maybe our recommended budget has done. At least it will make them go back and take a good hard look at where they stand.

Chairman Humphrey. Yes, but you did not need to choke the guy to death to make him take a look at where he is standing. There is

a total absence, total termination of construction grants. Is that not correct?

Dr. Edwards. That is correct.

Chairman Humphrey. Well, now, I would hope that you would take a careful analysis there and speak up in the Government. I know it is hard to do that sometimes, but we have to do something about it, because it is a fact that there are needs in construction.

I notice, for example, that the administration's proposal would have a severe cutback for neighborhood health centers. Now, we made a commitment to this country some years ago. I was part of that commitment. I was Vice President of the United States when that took place. We were going to build them all over the country, and I visited many of them. I have walked through these neighborhood health centers. We have one out in Minneapolis called Pilot City. We had a beautiful one in Denver that did a remarkable job, served thousands of people in the Chicano and Mexican-American community.

I have a study made in May 1973 by the GAO—in good old senatorial fashion, always showing the documents here. It is called "Implementation of a Policy of Self-Support by Neighborhood Health Centers." This study estimates that the potential reimbursements from third parties would range from 7 to 46 percent of total operating costs. This means that if the Federal support is withdrawn, many if not most of these centers will be forced to close.

Now, I recall that last week, you were before Congressman Rogers' subcommittee and you said that the administration placed a high priority on these centers. Now, is that in prayer or in money in the church plate?

Dr. Edwards. No, we are not decreasing our funding for the neighborhood health centers or for the family health centers. Our funding is remaining at the 1973 level, I believe, is it not?

Dr. Zapp. Yes. It was approximately $97 million in 1973 and it will be inscreased to about $197 in 1974 because of the OEO transfers.

Chairman Humphrey. Well, that is not really an increase, is it?

Dr. Zapp. No.

Dr. Edwards. It is just moving it over into HEW.

Chairman Humphrey. The fact of the matter is that the amount of money in fiscal 1974 for neighborhood health centers as far as the traditional neighborhood center picture is concerned for fiscal 1973 is about what, identical?

Dr. Zapp. Yes, it is comparable, Senator.

Chairman Humphrey. All right, now, how much before the impoundment business that went on in 1973? What about comparing it with 1972?

Dr. Zapp. Well, I do not have the detailed neighborhood health centers figures with me, Senator.

Chairman Humphrey. Was there not more in 1972?

Dr. Zapp. In neighborhood health centers?

Chairman Humphrey. Yes. That is our understanding, is that not correct?

Dr. Zapp. The outlays in 1972—I would question that, Senator, but I do not have those detailed figures on the neighborhood health centers.

Chairman Humphrey. I have been informed that the amount in 1972 was larger, despite the fact that inflation has eaten up a lot of the value

of the purchasing power of the dollar. You did not build anything in for inflation in 1974, did you?

Dr. Zapp. No, there is a bigger factor in neighborhood health center that needs to be examined and I think the GAO report begins to allude to it. This has been focused on capturing third-party reimbursement, from 7 to 34 plus percent. The information on physician patient visits per day on some of these has been less than satisfactory and their recapture of third-party reimbursements has also been less than satisfactory. We really will find that there will be an increased productivity in the neighborhood health centers in the next fiscal year, even though the direct Federal project grant assistance to them will be constant. And of course, some of that is going to be coming from other Federal programs.

Chairman Humphrey. Here is what GAO says: "In summary, the current operating practices of the NCH's and the nature of available third-party reimbursement programs severely limit the prospect of improving the neighborhood health centers' current level of self-support." Then it goes on to say that they believe the neighborhood health centers "can substantially increase their level of self-support by eliminating inefficient operating practices and by obtaining recognition as providers of services eligible under Federal and federally assisted programs."

My point with the neighborhood health centers is that this is one way that you have accessibility for the poor, in particular the ghetto resident, to reasonably good health care services—not always the best, but reasonably good. We have not been doing the job that we should on these health centers. How many do we have today, total, do you recall?

Dr. Edwards. I think it is around 500, but I am not sure. I would have to check that.

Chairman Humphrey. I think we have a list of them here now. Some of them are very small.

Are you satisfied with the numbers, Doctor? Do you think we need more? Do we need less?

Dr. Edwards. We certainly do not need less. As the GAO report brings out, what we have to do is make the ones we have as efficient and effective as possible. As you so ably pointed out, this is at least the best we have at the moment, the best way of providing health care services to some of these innercity depressed areas. We certainly are in support of the concept.

Chairman Humphrey. Have you examined the General Accounting Office's report on this?

Dr. Edwards. Yes, I have.

Chairman Humphrey. Do you have someone in your division of HEW working on this to implement this report?

Dr. Edwards. Yes.

Chairman Humphrey. There is some very critical analysis of health centers in this report.

Mr. Altman. We have just completed two additional studies on third-party reimbursement of health centers to try to find and break down those logjams that GAO recognized, particularly in providing buyer status for medicare and medicaid. We have a problem with the States on this. I do not think we should underestimate the problem,

because an individual may be eligible for medicaid, for example, but if the State pays the funds, it has to pay 50 cents and the Federal Government pays 50 cents under medicaid. If it is paid under the neighborhood health center grant, it is a full dollar from the Federal Government. So we have to work out State by State, quite often, the ability to break down sort of sub rosa—we are working on that.

Chairman HUMPHREY. I hope you will pursue this, because these are very good facilities. There are inadequacies, we know that, in the manner in which they are operated, because many of them have been put up in areas where the manpower, the amount of skilled manpower, is limited and the structural organization in terms of good management practices is not too good.

Mr. ALTMAN. Quite frankly, Senator, we do have a real problem with respect to the ability to meet a commitment of putting such centers up in all the places in the country that would qualify on the same income grounds. We have over the last couple of years created what we consider to be terrible inequities, where one community with the same income and the same overall demographic characteristics receives a center and the other ones do not. I think our posture is and will continue to be to move toward payments, national health insurance and other payment mechanisms, and try to help he privae sector develop. Because once the Federal Government comes in with the reimbursements that they have in the neighborhood health centers, they tend to perpetuate themselves. Quite often the service that these centers give is far in excess of that which any reasonable reimbursement system will ever pay for. That is a real problem.

Chairman HUMPHREY. Does this not just lead up to one thing, that some form of universal comprehensive health insurance is the way we are going to eliminate a lot of these diverse patterns of payments which result in more bookkeeping than an accounting firm can take care of?

Dr. EDWARDS. I think without any question.

Mr. ALTMAN. I think we would support that, yes.

Chairman HUMPHREY. We just have to come to something on it, because the recordkeeping thing is really monumental.

When is your report coming forth on health insurance, Mr. Altman? I do not mean your proposal, the administration's proposal.

Mr. ALTMAN. It will be sometime this summer. We are right now in the process of looking at the various options that are open and examining, discussing, and debating the various options. I would hope it would be sometime this summer.

Chairman HUMPHREY. Do you have advisory panels working on this with you, bringing in the related or the areas of the social structure that are concerned about this—the consumer, the person or persons or institutions that provide the services, the financiers?

Mr. ALTMAN. Yes. What we have decided to do is wait until we have the new people that have entered the Department and the administration in the health area. After they have taken an initial cut at the problem, and get an overall tentative feel for where we might be going, we then will institute a series of discussions with consumer, provider, and insurance groups to see that we are moving along, hopefully on the right track.

Chairman HUMPHREY. I think one of the greatest things this Government could do is straighten out this health delivery system and health

care system. The amount of money we are spending in this country for what we call health care is astronomical. It is not that we are not spending a lot of money, it is that we are not getting the service for the dollar that is required.

We have excellent doctors. We have outstanding modern hospitals. We have good personnel—not enough, in my judgment, particularly in what we call the paraprofessionals. I have heard lots of arguments about the number of doctors that we need. I have come to the conclusion that the numbers that we used to talk about may be excessive, particularly if you have the doctor doing the kind of work that he is supposed to do with his kind of professionalized training.

But let me go back on one other thing, Doctor, the subject of Hill-Burton. There are no funds at all in fiscal 1974 for Hill-Burton. Is that correct?

Dr. Edwards. There are no Hill-Burton funds, no.

Chairman Humphrey. What funds, if any, are there for the improvement or the establishment of outpatient clinics?

For modernization of hospitals that today are grossly inefficient because they are obsolete. Are there any funds?

Mr. Altman. Well, there are loan funds that are available.

Chairman Humphrey. What kind of loan funds?

Mr. Altman. Private loan funds and inner cities, one could qualify for certain FHA funds. There is not by and large, and one cannot generalize to every community, the private sector now has been willing to put substantial funds into the health care delivery system market. The real problems develop in the inner cities and here is where the FHA can help.

Chairman Humphrey. FHA—is that the Farmers Home Administration or the Federal Housing Administration?

Mr. Altman. The Federal Housing Administration. The big difference, with the introduction of medicare and medicaid, with most people paying their bills, you can build into the payment system large amounts for depreciation. We estimated about $700 million in depreciation funds will be spent by Federal programs next year and over $1 billion in private depreciation funds. These funds can and are being used to build hospitals.

Hill-Burton, which just 2 or 3 short years ago was funding in excess of, I think, 13 percent of the amount for construction, was down to about 4 as of a year ago. So that Hill-Burton really has become less and less of a vital component of hospital building. A national program like Hill-Burton no longer seemed necessary to get at the few problem areas that now exist.

Chairman Humphrey. It is necessary for the new general hospital in Hennepin County, I can tell you.

Mr. Altman. That may be one of the few problem areas.

Chairman Humphrey. And there are 131 counties in this country that do not even have a hospital. And there are a lot of hospitals—I know there is a surplus of hospital beds in the Twin Cities. There is not a surplus of hospital beds in western Minnesota. Are you going to drag everybody into the Twin Cities?

You know, I know my State, know it very well. When I go, for example, to see a little hospital out at Lake Lillian, Minn., it is a nice little community, very important community. It is a rural community.

They desperately need some assistance. And if these funds are knocked out, they are not going to be able to raise all those funds out there. And when we had the testimony yesterday from Mrs. Karen Davis and from the CED, Mr. Neal, they pointed out repeatedly the areas in which there is obsolescence and need of renovation and also need of funding. Many of these communities are not quite as well off, you know, as these Federal figures always indicate.

I do not know whom people are talking to. I must be in a different country than some other people around here.

Mr. ALTMAN. I would agree, it is not the amount of money the community has, it is the amount of money that is spent for the health care delivery system. Quite often, that comes from the Federal Government and State governments.

Chairman HUMPHREY. Yes.

Mr. ALTMAN. And while one can point to example after example, we know as you pointed out that we are spending $83.5 billion in this industry and 40 percent of it is going into hospitals. A significant portion of that is going for depreciation. That is the single fastest growing item. As I pointed out to Congressman Brown the single fastest growing item is plant, equipment, and depreciation. That is adding significantly to hospital expenses.

I am afraid we have to make one cut or the other. Either we have to come to grips with limitations on new facilities or we are going to continue to see 14 and 15 percent increases in expense per patient day. There is no other way. We can cut down a little on labor and we do not want to cut back on wages, but——

Chairman HUMPHREY. I would think Federal assistance would help make that cutback to the consumer.

Mr. ALTMAN. Well, that is just paying from one pocket, rather than——

Chairman HUMPHREY. Oh, no, it is not. We cannot tax a multinational corporation in Minneapolis: $200 billion worth of our gross national product last year was done by multinational corporations, much of which they do not pay much tax on. The only government that can tax them is the United States of America right here. Hennepin County cannot tax them. I know this tax structure. They are not going to give me that big load.

That is what is wrong with this budget, somebody in the OMB does not think any of us went to school. Now, some of us are old hands around here. We have been here a long time. When you start talking about where you can raise the money and the share of this and the share of that, you have to get down to specifics. Now, the simple fact is that many of these local areas do not have the revenue base if you are going to raise it out of taxes to pay for these things as compared to the Federal Government. The Federal Government has the way and the means to raise the revenues if it wants to do it. And of course, what is said all the time, as was said in your statement here today, is that if we do not do something about this, we will have to raise taxes.

Well, where do you want to raise them? Here or back home? Do you want to raise them on income of Exxon, or do you want to raise them on the income of Fred Swanson, aged 65? That is the question. Do you want to raise the taxes on people that are getting billions and

billions of profits, as the recent corporate estimates show—incredible profits? Or do you want to raise it on grandpa or on his grandson that cannot afford to buy a house?

Now, that is what the economic issue is here and that is why I do not like what I see in the budget, because there is an element of injustice and some of us know a little something about economics. We are not all just ignoramuses. We have been around. When I see cutbacks in programs such as are here—and I want to give you this little feeling of mine, because I think you are with us in heart. I know you have to defend a budget. I had to do it, too. But I want to tell you, I have been on the other side about that budget, too.

So I just, when I read, for example, that the medical schools are going to have their capitation grant funds down, their special project support down 34 percent, they are down 36 percent for curriculm improvement and 35 percent for minority enrollment projects—and I want to leave you just on that last one.

What about minority enrollment in these schools? Does not the present budget seriously cripple that? According to the testimony we had yesterday, it does.

Dr. Zapp.

Dr. Zapp. Well, Senator, I did not hear the testimony. I am not sure why it would.

Chairman Humphrey. Because you do not have the same amount of money for fellowships.

Dr. Zapp. Well, they would not be going to medical school fellowships.

Chairman Humphrey. On scholarships, I mean.

Dr. Zapp. As a matter of fact, on scholarships, we have proposed, it was included in the President's budget, $23 million for scholarships in the health professions. We are recommending that that be funded under the Emergency Health Personnel Act, in the hopes that it would be amended in this year.

What we are doing differently here is we are saying that along with the loan guarantees and other assistance available——

Chairman Humphrey. Are those loan guarantees for students? That is just pipedreaming. Have you been out trying to get some of those loan guarantees? Have you talked to people trying to get them?

You just go on out there and try to get one of those big banks and see how much of a loan guarantee you are going to get as a student.

Dr. Zapp. I think it cannot be held just as a single factor, but it is one of the factors.

Chairman Humphrey. Yes, but it has been sharply cut back. There are many institutions that are not doing it. I am out in the field. I do not think my part of the country is any worse than anywhere else. We may be a little more generous. We are very education oriented. One of our savings and loan companies out there has gone out of its way to extend these student loans, but a lot of institutions say it is too much bookkeeping, too much trouble, too much defaults; do not bother me; I would rather lend it to General Motors.

Dr. Zapp. I am not sure that holds for medical and dental students.

Chairman Humphrey. How about minority students?

Dr. Zapp. I think with minority students also. But you talk about a student, once he has been admitted to a medical or dental school.

He may be from a disadvantaged background because of minority or coming from a low-income family or a variety of other things. But at that particular point in time, he has an earning potential and reliability factor that far exceeds a student who has just gotten out of high school and is looking for a college to go to and for some kind of financial assistance.

The central point, Senator Humphrey, is that we are expending our scholarship program. The one difference is that we are proposing to target that to a return in Federal service.

Chairman HUMPHREY. Yes, I understand that.

Dr. ZAPP. We just feel that we have two needs. One is, we think, to make good use of the Federal dollar, which I am sure you agree with. The other is the fact that we have a personnel problem for some of our direct health delivery programs such as the Indian Health Service and the National Health Service Corps.

Chairman HUMPHREY. I have great interest in what you are talking about. I think there ought to be some requirement for some type of Federal service once you get these grants. But the problem is your change of program is not available now and you have cut out the other program so that you are going to have a problem here down the line unless the Congress of the United States is able to act a little more quickly than it ordinarily does on these matters where you will not have some of these funds available for the coming year.

Dr. ZAPP. I was certainly hoping in that one, Senator, that we are able to work in both the appropriation and the authorizing committees to get that amendment——

Chairman HUMPHREY. How long have you been around in the Government here?

Dr. ZAPP. I have been here a little over 4 years.

Chairman HUMPHREY. What is your experience on things like this? Do you think you are really going to get results that quick?

Dr. ZAPP. I have seen relatively few high-priority items move at that pace, Senator.

Chairman HUMPHREY. That is what I thought. We understand each other and I thought we ought to kind of make the record clear.

It may happen, and I hope it does. We, by the way, are calling this to the attention of the proper committees of the Congress and we are going to try to get it.

Maybe I have been misinformed, but Dr. Cooper said to me in this printed statement that the survey results of the American Association of Medical Colleges, the schools reported what they reported, down 35 percent for minority enrollment for the coming year. That is their estimate.

Dr. EDWARDS. I have reviewed those figures with him, Senator, and I really do not know how he arrived at that figure.

Chairman HUMPHREY. Those are the schools, what they said. Now, our own university gave me a figure, said that they would obviously have to cut. They have to lay off faculty, for example. That means you do not have students. The ratio of students and faculty in medical schools is pretty well set.

Dr. EDWARDS. Set, I question whether it is necessarily set the right way. I think it is set for the benefit of the faculty and not necessarily for the student.

Chairman HUMPHREY. Well, that is a generalized statement, Doctor.

Dr. EDWARDS. I recognize that.

Chairman HUMPHREY. I think there are abuses, I agree with that, and people get on terms that sometimes do not want to teach. I think research is pretty important.

My concern here is that for the short-term, the fiscal budget may very well—well, you may say, we can rock and roll with it and we will get by, even though it is going to cause great dislocation in many of our professional schools. I do not think there is any doubt about that. Now, whether that dislocation can be recommended is a subject that is open to debate. But down the road, we are going to pay the price.

When you do not have the number of graduate students in these high-cost schools—and they are high cost and I do not know how you can reduce those costs particularly—you are going to pay the penalty later on. They are going to have the lack of trainees, the lack of teachers, the lack of professionals down the road, because after all, a large number of our graduates today go into teaching. They have to go into teaching. We do need more nurses in this country, we do need medical technicials and we are going to need more hospital managers, we are still going to need more public health officers.

Now, we have an excellent public health school. Dr. Gayloard Nelson was one of the great public health officers of this country. Our public health school is a regional school. The State of Minnesota cannot take up all the cost and it is being gutted by the budget cuts.

I have the statement here that is nothing short of denying this country personnel that it needs for years to come. It is not a Minnesota school. It serves the entire area, it is part of the national resources. I just feel that the priorities are gummed up a little bit.

I do not say there is not some inefficiency, I do not say there is not some waste. I want you to get at it. But I think we are going at it through the OMB approach, with the meat ax rather than with the fine cutting that may be necessary to trim out fat.

I am going to let you go. You are very kind to come. We may want to submit for the record some questions.

I want to cooperate with you, Dr. Edwards. I am going to include in the record an excellent article that appeared in the Wall Street Journal concerning your work.

[The above referred to article follows:]

[From the Wall Street Journal, May 7, 1973]

HEW'S EDWARDS STRENGTHENING HIS CONTROL OF HEALTH PROGRAMS, PERHAPS TO THEIR GOOD

(By Jonathan Spivak)

WASHINGTON.—Dr. Charles C. Edwards, the new Assistant Secretary for Health in the Department of Health, Education, and Welfare, is moving to establish firm central direction over the department's massive medical programs.

To the extent he succeeds, it's probably good news for hospitals, doctors and patients. A former staff member of the American Medical Association and more recently commissioner of the Food and Drug Administration, Dr. Edwards is sympathetic to the needs and traditions of the medical profession. But in his FDA post he also displayed a willingness to stand up for the consumer and oppose doctors and the drug industry on several controversial issues.

Dr. Edwards is also probably slightly more liberal in his approach in health-care spending than the Nixon administration itself, and to the degree he establishes an independent status within the department he could turn out to be a strong defender of health programs currently under vigorous attack.

As a first step towards strengthening the Assistant Health Secretary's control over programs, a reorganization plan for the department's health agencies was announced Friday. The changes mapped out by a committee headed by one of Dr. Edwards' FDA associates break up one of the department's major health units, the Health Services and Mental Health Administration, into three more manageable units.

Dr. Edwards made clear in an interview that the unit's size and undefined purpose was a major obstacle in efficient management of the department's health programs. "It is so complex and so many units are involved that it takes you all day to explain what its mission is," Dr. Edwards said. The reorganization would break this agency into a Health Services Administration and Health Resources Administration, while giving more independence to the existing Center for Disease Control.

The three units each would be headed by an administrator who would report to Dr. Edwards, as do heads of two existing HEW health agencies, the Food and Drug Administration and the National Institutes of Health. In addition, the current semi-autonomous National Institute of Mental Health would be made a part of the National Institutes of Health, which originally had jurisdiction over it some years ago.

These steps would strengthen Dr. Edwards' office and its control over the Medicare and Medicaid programs administered by other units in the department. Dr. Edwards hopes that through this strengthening process, which probably will include future steps, a central focus for HEW health activities will result. It is a goal that has eluded all of his predecessors. "There never has really been developed a federal health strategy because HEW never had an organization or an agency to develop one," Dr. Edwards maintains.

A VOICE IN BUDGETS

As further bolstering of his authority within the department, Dr. Edwards won a strong voice in the budgets of the health agencies that report to him, along with the right to veto the selection of any officials to head these units. At present, because of delays in getting replacements, the existing health agencies are without chief administrators, and only one post created by the reorganization has been filled. Harold O. Buzzell, a former Labor Department deputy manpower administrator, will help carry out the reorganization and will head the new Health Services Administration.

So far, Dr. Edwards has maintained a low profile in his new post. He was one of the first officials chosen by new HEW Secretary Caspar W. Weinberger in assembling the team to run the department in the second Nixon administration. Part of this invisibility probably stems from Dr. Edwards' desire to avoid controversy. As FDA commissioner, he frequently sought to mollify both sides, consumer and industry, in the tough drug regulation controversies he steadily faced. Nonetheless, as FDA commissioner Dr. Edwards prepared increasingly willing to stand up for the consumer on such matters as forcing some prescription drugs like amphetamine combinations off the market, pushing for stronger standards on over-the-counter compounds and releasing more information about the agency's activities and scientific decisions to the public.

In his new post, Dr. Edwards is likely to be forced increasingly into public and controversial stands, as he must deal with politically difficult issues of organization of health care, policing of the quality of doctors' services and control of the rapidly rising costs of medical care. The immediate problem confronting him is defense of the administration's efforts to cut out a number of such long-established health programs as the Hill-Burton hospital construction program. The administration claims they are wasteful and aren't needed any longer.

ACCEPTS NIXON HEALTH PRIORITIES

The outcry against these proposed curtailments also is one reason that Dr. Edwards has sought to remain in the background for now. Although he argues that he hasn't any quarrel with the health priorities established by the Nixon administration and buys its view that more concern with benefits obtained from the federal health dollar is essential, the cutbacks put him in a tough position with the health profession.

Too public a position might make Dr. Edwards risk losing the credits and credibility he currently enjoys with doctors and other health professionals. But he isn't likely to simply serve as their spokesman either. Dr. Edwards argues

that in the past the view has been prevalent that "where the federal health dollar is used you don't have to worry about cost-effectiveness because the well is a deep well." But he adds, "I think this philosophy has to change."

Dr. Edwards will have major problems in carrying out an about-face on this score. The biggest obstacle will be his lack of control over Medicare and Medicaid, health insurance for the aged and the federal-state welfare Medicaid, which account for 80% of the department's health expenditures. Medicare is run by the Social Security Administration and Medicaid is administered by the Social and Rehabilitation Service, two other HEW units that don't report directly to Dr. Edwards.

One option that wasn't immediately adopted in the health reorganization was the transfer of these two programs to the newly created Health Service Administrations. Some health experts within the department argued that this step was the crucial one to giving Dr. Edwards the authority he needed over federal health programs. But it obviously would open up a bureaucratic battle with those officials who wanted to keep programs within their own bailiwick, and it could produce a backfire on Capitol Hill with some Congressmen who are strong supporters of Social Security Administration control over Medicare.

The upshot for the present was a statement by Secretary Weinberger that Dr. Edwards and other HEW officials would try to work out ways to "strengthen the policy role of the Assistant Secretary of Health in the Medicaid and Medicare programs." It's far from clear precisely how this will be done, and the possibility certainly is left upon that within the coming year, particularly if a new national health insurance program becomes imminent, the programs will indeed be transferred to Dr. Edwards' office.

REVIEW UNITS TO BE SET UP

Despite his eagerness to keep out of the spotlight, Dr. Edwards made evident some of his convictions on the substantive issues he confronts. He considers his priority the establishment of medical-review organizations, known as professional standards review organizations, a requirement of last year's Social Security legislation.

Dr. Edwards argues that the review effort "will lay an egg if we don't get responsible medicine involved in it." He contends that improved review of the quality of health care to patients should indeed lower the cost of health care rather than increase it. One reason, of course, is that tougher auditing of medical practice could eliminate unnecessary care.

Dr. Edwards maintains that the allied problems of alcoholism and drug abuse "are probably society's biggest problems today." For that reason, he may favor giving separate and more independent status to institutes within the National Institutes of Health, the existing National Institute for Alcoholism and Alcohol Abuse and a new National Institute for Drug Abuse to be established next year.

The Assistant Health Secretary argues that the cutbacks in support of the training of medical faculty and medical researchers by the National Institutes of Health should be watched for their ultimate impact. He argues that only time will determine whether other sources of support are adequate, and, if they aren't, new steps might be necessary to maintain the supply of basic scientists.

He favors imposing patient payments for health insurance as a means of controlling costs, and he sees merit in plans currently discussed with the administration to broaden the coverage of the proposed Nixon health insurance plan.

Chairman HUMPHREY. I think that you offer us some real hope and I am going to be the bad boy with the OMB, because I never have much liked these budget burrs. I did not even like them under Democrats and I do not like them much better under this one, because I have a feeling that they do not know the people. I have spent my whole life working with people. That is all I do. If I do not know my people in Minnesota, then I have sure been missing the boat. I know those schools out there and I am going out to Rochester tomorrow morning. We have been trying to get a medical school and we have a pretty good clinic at Mayo, just for openers. It is a high-class medical school. We have another medical school being established out at University of Minnesota at Duluth.

I do not need to get any lectures from the President on self-reliance, on the work ethic. My father gave me all that. We have been taxing our people at a high rate. We have a high tax rate in Minnesota, regrettably. And we put a lot of money into education. But the Federal Government reneged on us. I want you to come and clean up that contract, Dr. Edwards. You inherited it; I am sorry. You are in a trusteeship role here. So I want you to take a look at that commitment that the Federal Government made to my State and see if we cannot find that money, because I believe in contracts. I cannot sue you, but I can harass and I am going to do it from the Senate floor until the Federal Government keeps its word.

I do not believe that the Secretary of HEW ought to deceive the American people and the Secretary did not do that and the President did that. And they deceived the Minnesota Legislature, they even deceived a Republican Governor, and they deceived the president of the University of Minnesota. And it is wrong. it is dead wrong. And until the Department cleans that up, they are going to have troube with me, because I came down here to represent the people of Minnesota, and I am going to do it, no matter whether I am polite or not.

I have a great respect for you and I do do not want to be mean to you, but I am going to be tough on you.

Thank you very much.

Let me just for the record note that we have Mr. Glenn Wilson, associate dean of the School of Medicine, the University of North Carolina. Mr. Wilson has extensive experience in health planning and has been a consultant and adviser to at least six different group health organizations in United States and Canada. He has been executive director of the Community Health Organization Foundation of North Carolina.

Mr. Wilson, we are delighted that you could be with us today. You may want to present the gentleman with you.

Is this Dr. Mayer?

STATEMENT OF GLENN WILSON, ASSOCIATE DEAN, COMMUNITY HEALTH SERVICES, SCHOOL OF MEDICINE, UNIVERSITY OF NORTH CAROLINA, ACCOMPANIED BY EUGENE MAYER, M.D., ASSISTANT PROFESSOR, DIVISION OF COMMUNITY MEDICINE, DEPARTMENT OF FAMILY MEDICINE, UNIVERSITY OF NORTH CAROLINA

Mr. Wilson. Yes, it is Dr. Eugene Mayer of the Division of Community Medicine, the Department of Family Medicine, University of North Carolina.

Chairman Humphrey. I beg your pardon. I had a witness list here that indicated that you were not coming. Now I find you have been here all this time. I am really very sorry that I prolonged the first testimony so long. I beg your forgiveness.

Proceed if you will.

Mr. Wilson. Senator, the last time we had a chance to talk was with the mayor of Cleveland some years ago and I enjoyed myself thoroughly.

Chairman HUMPHREY. Yes, I remember that. It was in the mayor's office, was it not?

Mr. WILSON. Yes, sir.

Senator, we have submitted a prepared statement at the request of the subcommittee and in view of the testimony yesterday and the discussion this morning, I would like to just touch a few of the highlights.

Chairman HUMPHREY. We will include the entire prepared statement, of course, in the record.

Mr. WILSON. It has become fashionable in recent years, regardless of political party or philosophy, to talk about health care as a right of every American citizen. We would hope that we could move more rapidly toward that socially desirable objective than we did in agreeing upon it. The progress thus far has been inordinately slow and there is much yet to be done.

As the social pressures for service increase and costs continue their inflationary spiral, simplistic, politically expedient actions are most likely only to continue to add more bits and pieces and to continue to aggravate the problem.

There is little evidence in current proposals before the Congress, or in the administration's budget message, that we have carefully evaluated the errors of the past and that we will be doing anything more than continuing the patchwork during the next several years.

Chairman HUMPHREY. I think that our previous witness indicated that in his testimony.

Mr. WILSON. I would agree.

We believe that significant and rather fundamental changes in health care are in order. However, in our opinion, the current situation calls for carefully evaluated selective changes rather than the wholesale, unsupported action called for by some. Such changes are needed because a significant number of people are not receiving either adequate care or the most appropriate care. However, the objective evidence on what is adequate and appropriate is still elusive. There is still, and likely to continue to be, disagreement on the number of days of hospitalization which are necessary for a specific illness, or on the number of office visits needed for the same illness. In the face of these unknowns, we have generally proceeded to build more hospital beds while ignoring ambulatory care facilities. This is discouraging in view of the troublesome potential that the human capacity to absorb health services is unlimited. The Joint Economic Committee should then probably look at the fact that supply creates its own demand or, as we look at the decades ahead, we may be building a self-fulfilling prophesy.

We would like to talk about two or three specific areas, financing, manpower, and facilities planning. In the 20 years from 1950 to 1970, the trade unions primarily assumed responsibility for the financing of health care through collective bargaining. The Federal Government then joined in this in a major way with the enactment of medicare and medicaid. But in every instance where this was done, there was little if any discussion or examination of the capacity of the resources needed to provide the care. We simply pumped in the money. Inflation could only be the result of that kind of behavior. As we have seen, as prices went up, the system simply raised the prices. This year's ceiling became next year's floor.

If one assumes in the previous discussion on national health insurance that the white middle-class in the United States has adequate provision for medical care, and we think the definition of adequacy is quite elusive, we would then have to produce a hundred million additional out-patient visits a year this year to bring every citizen to the level of the white middle-class. That would be a 20 percent increase in our current production. Dr. Mayer and I have serious doubt that the resources are available to permit this and if the money is put into health insurance, once again inflation will only be further fueled. It is unlikely that available resources, once again, will allow us to attain that immediate goal, even if adequate financing were to become available.

Conventional wisdom in the United States has led us to believe that deductible and coinsurance are a barrier to unnecessary demands for health care. We would agree that they are a barrier to the poor, the near poor, the medicare people and the medicaid people, but they are not a barrier, as has been established, for the middle-class population, who are putting the great heat on the Nation's health system. However, deductibles and coinsurance in fact do become a barrier in any system for the poor and the near poor. Also, major medical insurance, although indicated on a selective basis is likely to find length of service going up and services provided without adequate controls. I would hope that Dr. Edwards' comments are right, that we have the capacity for PSRO so we can bring this under control, but I think the objective data is that we are a long way from it. I will not speak for my colleague, but I doubt that we have enough information to do more than limited coverage for PSRO. I would hope Dr. Edwards would be right, but I am doubtful.

Chairman Humphrey. I think he indicated that it would be quite a test, but he did not put his word on the line that it would be able to do the job.

Mr. Wilson. I would hate to make it a major point, because I am not sure we have enough insight into the problems to do it.

The other area we would want to talk about is the area of manpower. One consequence of our frustration with the poor response of the medical care system has been the proliferation of new forms of health manpower. Now, some of these are clearly indicated. We are involved with family nurse practitioners and they are working extraordinarily well in our rural areas. However, we now have 422 different job descriptions in the health field and as these new groups are developed, they form a national organization, they develop the habits of the other national organizations. They all work under the banner that they have some of the answer or most of the answer, if not all of the answer, for the health care needs of the American people. A very complex, intertwined guild structure is developing, in fact, has developed, in the health field. I would suggest that one would have to be back to the feudal era in Europe to find what guilds did to immobilize the formal structure of society. I think this is an issue that has been grossly overlooked as we have looked at health care.

We do not believe that honest concern about this proliferation of guilds and professional groups calls, however, for the elimination of training grants and new programs. For example, the last session of Congress committed this country to a renal dialysis and transplanta-

tion program estimated to cost $135 million the first year and a billion dollars thereafter. The President proposes now to eliminate the $12 million training grant program for kidney disease at the National Institutes of Health. If we are to find the answer to the problems of immunology, rejection of transplantations, et cetera, we must have the knowledge that will come from these grants. We are not prepared to argue that all training grants have been used entirely appropriately. I was particularly impressed with Congressman Brown's questions concerning playing this game honestly, changing the training grants to strict support of medical education. The real danger at the moment across the country is that as training grants are cut back in a fairly arbitrary manner, young faculty members are getting quite concerned. I think there is not a medical school in the country that is not watching very carefully about promotions as faculty members move up to tenure. This may very well have more far-reaching consequences than the chairman suggested, because as these people are denied promotions at the instructor or assistant professor level, we will have lost our teachers for several decades in the future. So there is great anxiety about having an abrupt change in health policy because it may cause the academic career of these people to be terminated. This is particularly troublesome in view of the fact that there are significant opportunities enticing them to practice in various communities.

Now, there is no more acute need in the State of North Carolina, and I would think Minnesota, than to bring about a better distribution of health personnel in our rural areas and in the ghettos. The National Health Service Corps started 2 years ago. Now we understand that it is to be terminated. A specific point of concern to us is what appears to be Federal action that is counterproductive to bringing about better health manpower distribution. When medicare and medicaid was enacted, they adopted the usual and cutomary fee schedule. Since the usual and customary fee in the rural areas was lower than it was in the urban areas, physicians concerned about medicare and medicaid people will now find for the same patient, for exactly the same procedures, he may be paid twice as much to do the procedure in a suburban community as he would be in a rural community where he is desperately needed. If one simply looks at the current Federal economic policy, it would appear that we are interested in concentrating physicians in the larger suburban communities rather than in the areas where they are needed.

There is also abroad in this country the notion that there are thousands of young Americans willing and anxious to go tens of thousands of dollars into debt to get health professional training. We are convinced that the number and character of the applicants to medical schools and other health science schools will take a sharp turn toward the upper middle-class and the upper class if we go to the loan program. This is particularly tragic in view of the very real progress which has been made in the last few years in the enrollment of disadvantaged and minority students.

I would like to turn to facilities and planning. We would agree that as a generality, in the nation as a whole, there is a surplus of hospital beds. But this hardy justifies the termination of the Hill-Burton program. Loans and local resources are offered by the administration to

support hospital construction and outpatient facility construction. The communities in need are those that do not have the capabilities of either borrowing the monies or of raising bond issues locally, which would make it possible to build facilities which are going to be essential to recruit health manpower.

There is another example of Federal policy which has very badly misfired. That is the matter of comprehensive health planning. This stimulation by the Federal Government has brought about, in essence, franchising for hospitals in several States. The social security amendments in 1972 sharply limited payments to hospitals which are not approved by the Comprehensive Health Planning agencies. The proprietary hospitals in large measure have avoided Comprehensive Health Planning. In our State of North Carolina, the Supreme Court has just ruled that you cannot bring proprietary hospitals under Comprehensive Health Planning. So, in fact, those hospitals which have shown the least motivation to serve those in greatest need, to locate in rural areas, to build the expensive emergency room, et cetera, are now free of the Comprehensive Health Planning Agency.

In the past, Senator, we have been able to at least use moral suasion to get the proprietary hospitals to look after medicaid people. The social security amendments now give them a legal argument to say they are prohibited from caring for medicaid eligible people by Federal action. As a result they are building and proliferating private hospitals and skimming off the cream and have the potential to do great damage to the public voluntary hospital system.

Chairman Humphrey. The Social Security Amendments of 1972 that you referred to giving the proprietary hospitals at least some reason to not take the medicare patient results from the fact that they are not under the Comprehensive Health Planning Agency.

Mr. Wilson. If you do not get your certificate of need from the Comprehensive Health Planning Agency there are severe strictures on payment under medicare and medicaid. Therefore, they are now using this as an argument that the Congress has prohibited them from taking care of medicaid and medicare people.

Chairman Humphrey. I see.

Mr. Wilson. We have come to the conclusion that in the absence of a comprehensive national health policy, this country is unlikely to restrain the cost of health care or to make quality care available and accessible to every American citizen. Such a policy must pay due consideration to the legitimate interests of the consumer, the educational institutions, the providers and their organizations, and the insurance companies.

It must also recognize the overriding consideration that in the health care field supply creates its own demand. Inappropriate arrangements in health care delivery will be utilized and their utilization will, in turn, be used to justify their appropriateness.

The country is not yet so homogeneous that one piece of legislation can be drafted which can be equally effective in all areas. A national policy must take into account the needs, expectations, and demands of the individual consumers, the providers of health services, the institutions training health personnel and the health services organizations. A policy must take into account facilities, financing, manpower, and utilization and bring each of these factors into some kind of balance.

Finally, these factors must be put into an organizational structure which is responsive to the public and accountable for its performance.

It would appear that the only body capable of developing such a national health policy is the Congress of the United States. We suggest the following specific points for your consideration:

(1) A health policy should have guidelines with sufficient flexibility to meet the unique problems of the several States. Undergirding principles should include the concepts of regionalization and areawide responsibility at each level.

(2) A health policy should develop long-term and short-term plans which will bring into some kind of balance the effective demand for health services with the supply and distribution of appropriate physical and personnel resources.

(3) A national health policy, once established, must be approached with sufficient consistency and continuity to truly test the potential of each of the parts. This becomes particularly important if insitutions and providers at all levels are to make long-term decisions in order to become true partners with the Government. We would join in saying that in 1971, the schools of public health, nursing, pharmacy and medicine, were encouraged to make significant enrollment increases and changes in their program. If those programs are abruptly terminated and contracts canceled, as the Senator spoke about in Minnesota, it will be some time before trust and confidence in Federal programs can be reinstituted. We can add to your school in Minnesota, if the Senator wishes, our school of public health which serves regional interests. It is on the bridge of bankruptcy because of Federal action. This is 2 years after it was stimulated very heavily to increase the number of students. Now we are told unofficially that the Federal capitation grants for medical students are likely to be terminated in 1974 and we have already begun to expand class size and faculty. The nursing school went to 150 students at the request of the Federal Government. They will lose their money on July 1. They have recruited faculties, developed all kinds of programs in order to do this. I do not know what they are going to do now. Under the difficulties, I am sure the Senator will understand that you cannot turn 30 or 40 more students into a class 1 year and terminate it the next year, which is the position we are in currently.

(4) A national health policy must appropriately stimulate a health balance of resources between the delivery of health care services, the education of health care providers, and basic research. The latter must encompass both biomedical research and research involving the delivery system. Neither can bring the maximum benefit of their findings to bear upon the health of the American people without the complementary aspects of the other.

We will be happy to try to answer any questions.

[The joint prepared statement of Mr. Wilson and Dr. Mayer follows:]

JOINT PREPARED STATEMENT OF GLENN WILSON AND EUGENE MAYER, M.D.

Mr. Chairman and members of the committee, I am Glenn Wilson, Associate Dean, Community Health Services, School of Medicine, University of North Carolina, and with me today is Dr. Eugene Mayer, a member of the Division of Community Medicine, Department of Family Medicine at the University.

It has become fashionable in recent years, regardless of political party or philosophy, to talk about health care as a right of every American citizen. It is

to be hoped that we move more rapidly toward that socially desirable objective than we did in agreeing upon it. The progress thus far has been inordinately slow and there is much yet to be done.

Private and public investment in the past two decades has produced an outstanding body of biomedical information, a tremendous number of well-trained health professionals and superb physical facilities. However, in a society without a clear public policy, these elements have been put together in a manner which is often unresponsive to public needs, and which lacks mechanisms for accountability and creates a fragmented approach.

The delivery of comprehensive, quality health services to every American encompasses an exquisitely complex social, cultural and political process. It is probably not obtainable without close cooperation and coordination between the Federal, state, and local governments; educational institutions; health care providers and their organizations; and the insurance companies. Although generally motivated with the interest of our citizens as the primary concern, our history of uncoordinated action has led to unproductive or counter-productive results. It is not surprising that social pressures for more and better services continue to be felt. As the social pressures for service increase and costs continue their inflationary spiral, simplistic, politically expedient actions are most likely only to continue to add more bits and pieces and continue to aggravate the problem.

There is little evidence in current proposals before the Congress, or in the Administration's budget message, that we have carefully evaluated the errors of the past and that we will be doing anything more than continuing the patchwork during the next several years.

We will conclude our presentation today by recommending a coordinated approach to remedial action. We will begin, however, by addressing several important categorical issues. We do this for two reasons. The first relates to current calls for legislative action on these issues. The second is to point out the problems which have developed in the health care system as a result of the categorical approach to program development in the past.

We believe that significant and rather fundamental changes in health care are in order. However, in our opinion, the current situation calls for carefully evaluated selective changes rather than the wholesale, unsupported action called for by some. Such changes are needed because a significant number of people are not receiving either adequate care or the most appropriate care. However, the objective evidence on what is adequate and appropriate is still elusive. There is still, and likely to continue to be, disagreement on the number of days of hospitalization which are necessary for a specific illness, or on the number of office visits needed for the same illness. In the face of these unknowns, we have generally proceeded to build more hospital beds while ignoring ambulatory care facilities. This is discouraging in view of the troublesome potential that the human capacity to absorb health services is unlimited and that supply creates its own demand. The Joint Economic Committee, charged with developing the long-range economic policy for the country, might do well to keep this in mind for the decade of the eighties and nineties.

Government policy is all too often characterized by enthusiasm for a specific program announced on an inadequate base of objective data and taken out of context of the structure of the system. Programs are then frequently terminated or de-emphasized, leading to further dislocation of the system before we have had an opportunity to demonstrate results.

We offer the following specific examples:

I. FINANCING

In the twenty years from 1950 to 1970, the decision on how much money would be available for health care was largely determined in employer-employee relationships and by the mid-sixities by the Federal government. Large sums of money were poured into the health care system with little or no regard for and certainly with little prior discussion of the resource capacity to provide the service. Runaway inflation could only be the result of this approach. In the fities, trade unions responding to their membership went to the collective bargaining table and tied up large sums of income that could only be used for health care. There was no systematic evaluation of the capabilities of the health care system to deliver the services. As effective demand rose rapidly, the free enterprise health care system naturally responded with price increases. One year's ceiling became the next year's floor. The response of collective bargaining was to obligate the

employer to pay the cost regardless of how high. Inflation was further fueled.

In this context, if one assumes the white middle class has adequate and appropriate medical care and uses their utilization rates as the yardstick for all Americans, the nation will have to produce 100 million additional outpatient visits a year to bring everyone up to that standard. This would require a net increase of 20% in the number of outpatient visits per year. It is unlikely that available resources will alow us to attain that goal in the immediate future even if adequate financing were to become available.

The conventional wisdom in the United States has led all too many people to believe that deductibles and co-insurance are a barrier to unnecessary demands for health care. If the deductible and co-insurance feature is small enough to be no more than a nuisance tax, the poor and near poor especially may be barred from seeking health services. There is no body of evidence to show that deductibles and coi-nsurance, except those that prohibit the poor from getting any care, are effective in reducing demand. Deductibles in one area tend to exaggerate demand in another area. Nonpayment for ambulatory services tends to increase the pressure on hospital care. Deductibles and co-insurance redistribute the cost of health care from the insurance company or the federal program to the individual, but there is no evidence that these measures are effective in providing constraints on the demand for services.

There is also great excitement about major medical insurance because of the tragic consequences that large medical bills have had upon many American families. The number of individual examples is truly startling. Carefully designed coverage for catastrophic illness is necessary. Blanket catastrophic health insurance with large deductibles, which is the manner in which it is generally provided, excludes the poor and near poor who have neither the resources nor the basic health insurance to obtain the services which allow them to advance beyond the stage of the deductible. Catastrophic insurance can once again pump large sums of money into a system unprepared to use it carefully. While it is desirable to remove the fear of financial collapse due to illness from our citizens, it appears as if such decisions should be made in tandem with decisions which improve the adequacy and appropriateness of the resources needed to deliver the services.

II. MANPOWER

The decade of the sixties witnessed an explosive public demand for health services which was vastly beyond the capacity of the providers. The initial lethargic response of both the educational institutions and the providers only increased the frustration. One consequence of this frustration has been the creation of a wide variety of new health professional roles to fill the void. There are currently 422 different job descriptions in the health field. Although increasing emphasis is being placed upon the health care team, the nation runs the risk of further fractioning the delivery of service at a time when the public is clamoring to be treated as a whole person. As new professional groups have emerged, they have inevitably formed national organizations and, following the lead of established health professional organizations, have taken on all the trappings of a guild—each asserting, under the banner of good patient care, that they hold an important answer to the national health care problem. One needs only to re-read the history of the feudal era in Europe to see how a tight guild structure immobolized that society.

Honest concern about the proliferation and entrenchment of the guilds does not, however, justify the wholesale cessation of training programs. Again, careful evaluation and selective alterations are in order.

Except for a very recent statement to the contrary, there appears to be broad agreement that the nation needs more physicians. In addition, there is considerable need for nurses, dentists and selected forms of allied health professionals. It is not necessary to defend all training grants of the past two decades. A careful evaluation would indicate that they have provided the faculty to teach the health professionals of the next generation. It is necessary, however, to augment the focus of these programs and to add programs which stimulate training in primary care related areas. But any modification or elimination of these programs must only be done while asking who will provide the educational leadership in the decade of the eighties, both at the university health science centers and in the area health education centers established in the 1971 session of the Congress. If we eliminate training grants in their entirety, the answer to this question is a foreboding one.

For example, the last session of the Congress committed this country to a renal dialysis and transportation program which is expected to cost $135 million in 1974 and to increase to a billion dollars annually thereafter. To proceed with this kind of a commitment while at the same time terminating the $12 million training grant program for kidney disease for the National Institutes of Health seems to be an imprudent act. It would not have been possible for the Congress to enact this important renal dialysis program without earlier basic research, and although tremendous progress has been made, further basic research is required if we are to have the knowledge to effectively manage and contain this life-threatening disease, and perhaps to do so at a lessened cost. In fact, additional training grants to allow for work in the prevention of the illnesses leading to the need for expensive renal dialysis should be considered along with the above.

There is no more acute need in the health care field than to bring about a better distribution of health personnel. There has been only a limited effort in this area for too long a time. The National Health Service Corps, designed to provide some short-term help to communities, came into operation two years ago and is now proposed for termination. The Comprehensive Health Manpower Training Act of 1971 established Area Health Education Centers as one way to deal with the training and distribution of health manpower. It is to be hoped that this program to which at least 10 university medical centers and their regional hospitals have made deep and long-term commitments, will have a reasonable opportunity to demonstrate its capabilities.

In spite of the recognized problem of manpower maldistribution, some action of the Federal government appears to be counter-productive to bringing about a better distribution of personnel. The enactment of Medicare and Medicaid brought forth a fee schedule based upon the so-called usual and customary fees of the area. In doing this the higher fees in the urban and suburban areas were accepted along with the lower fees of the rural and ghetto areas. The discrepancy was cast in the concrete of a relative value schedule. To the extent a young physician is concerned with Medicare and Medicaid patients, he will inevitably find that he will be paid twice as much for exactly the same procedure on exactly the same person in an urban area as he would in a rural community which desperately needs his services. One could only conclude that the current use of the Federal government's economic power is being directed towards concentrating health personnel in the urban and suburban area.

Finally, there is abroad the notion that thousands of young Americans are eager, willing and able to borrow the funds to receive their health professional education. It occurs to us that this strikes at the very heart of a democratic society with a commitment to public education. The number, quality and character of applicants to medical school and other health science schools are likely to take a sharp turn toward the upper middle class and upper class if the family is expected to go tens of thousands of dollars into debt in order to secure that education. This is particularly tragic in view of the very real recent progress which has been made by medical schools in the enrollment of disadvantaged and minority students.

III. FACILITIES AND PLANNING

There is some agreement that for the nation as a whole there is a surplus of hospital beds. This hardly justifies, however, the destruction of the Hill-Burton program since there are areas in the cities and especially in the rural areas which desperately need upgraded facilities if they are to attract health personnel to meet their needs. Selective building of hospital beds and more widespread building of ambulatory care facilities is in order.

There is yet another example of Federal policy which has misfired. This relates to the urgent need to systematically and carefully evaluate and plan expensive hospital facilities based upon area need across the country. The development of comprehensive health planning agencies has been initiated by Federal action which in turn has stimulated some states to enact franchising laws which sharply limit the unnecessary expansion or construction of hospital beds. These activities began to offer the hope of bringing some order into the development of expensive hospital facilities while eliminating waste and duplication.

In recent years there has been substantial intrusion by proprietary interests in the predominantly non-profit hospital system. Proprietary hospitals have to some extent avoided the supervision of these planning organizations, and in at least one instance, our home state of North Carolina, the state Supreme Court

has ruled that proprietary hospitals cannot constitutionally be brought under Comprehensive Health Planning.

This set of circumstances is unfortunate because proprietary hospitals have shown little, if any, inclination to develop hospitals in areas of most acute need, to serve the Medicaid population, or to develop those expensive standby services so important for public health (viz, the emergency room, obstetrical and pediatric units, and outpatient clinics). In the past it has been possible to bring public pressure against these hospitals in an effort to get them to accept more of the total public responsibility. The Social Security Amendments of 1972 covering Medicare and Medicaid recipients sharply limited payments to hospitals which are not approved by the Comprehensive Health Planning Agencies. However, in view of the recent court decision in North Carolina, proprietary hospitals are now restrained from serving the patients in most need, namely, Medicaid and Medicare recipients. They are free to serve only those that are most likely to assure the success of their profit-making venture.

Summary and recommendations

We are forced to conclude that in the absence of a comprehensive national health policy, this country is unlikely to restraint the costs of health care or to make quality care accessible and available in its most appropriate form to every citizen as a right. Such a policy must pay due consideration to the legitimate interests of the consumer, the educational institutions, the providers and their organizations, and the insurance companies.

It must also recognize the overriding consideration that in the health care field supply creates its own demand. Inappropriate arrangements in health care delivery will be utilized and their utilization will, in turn, be used to justify their appropriateness.

The sweeping social legislation in the decade of the sixties has demonstrated the difficulty in writing detailed Federal programs which are equally effective for our major urban areas and for the rural sections of our country. The country is not yet so homogeneous that one piece of legislation can be drafted which can be equally effective in all areas. A national policy must take into account the needs, expectations and demands of the individual consumers, the providers of health services, the institutions training health personnel and health services organizations. A policy must take into account facilities, financing, manpower and utilization and bring each of the factors into some kind of balance. Finally, these factors must be put into an organizational structure which is responsive to the public and accountable for its performance.

It would appear that the only body capable of developing such a national health policy is the Congress of the United States. We suggest the following for your consideration:

I. A health policy should have guidelines with sufficient flexibility to meet the unique problems of the several states. Undergoing principles should include the concepts of regionalization and areawide responsibility at each level.

II. A health policy should develop long-term and short-term plans which will bring into some kind of balance the effective demand for health services with the supply and distribution of appropriate physical and personnel resources.

III. A national health policy, once established, must be approached with sufficient consistency and continuity to truly test the potential of each of the parts. This becomes particularly important if institutions and providers at all levels are to make long-term decisions in order to become true partners with the government.

IV. A national health policy must appropriately stimulate a healthy balance of resources between the delivery of health care services, the education of health care providers, and basic research. The latter must encompass both biomedical research and research involving the delivery system. Neither can bring the maximum benefit of their findings to bear upon the health of the American people without the complementary aspects of the other.

Mr. Chairman, we will be happy to try to answer any questions.

Chairman Humphrey. I have just a few questions here that we have prepared as a result of reviewing some of your testimony.

The 1974 budget proposes to increase the amount the people over age 65 may pay for medical care by raising the coinsurance portion of medicare and medicaid. You are familiar with that, of course. Yesterday, Mrs. Karen Davis testified that coinsurance on hospital charges

encourages patients and physicians to select less expensive hospitals and to reduce excessively long delays and by so doing, discourages hospitals from charging exorbitant fees. However, she went on to say that there should be a ceiling on these payments. They should be related to income and any savings generated should be used to improve protection against other expenses.

Put in this context, do you believe that coinsurance can be a useful part of the overall health coverage?

Mr. Wilson. From my experience and the literature available to me, I am unpersuaded by coinsurance, Senator. I do not think that the patients' right to select a hospital is very meaningful. It is almost never done.

Secondly, I would say that there is too much attention being paid to the cost of hospital care. There is a problem there, no doubt about it. But it is the inappropriate use of the hospital which raises costs. In addition, we might find disastrous results by looking for a cheaper hospital. A cheaper hospital is not always the best place. I am less concerned about the expense per day than I am the number of days which are other than medically necessary.

Chairman Humphrey. Right.

Mr. Wilson. Coinsurance for people who have money has shown no signs of prohibiting excessive use. Coinsurance and deductibles drive the poor out of the markets and reduce their demand. If it is adopted as Government policy to pass part of the tax burden back on the Medicare people, then a reduction in demand by the people can be effected by this system. But that is all I would see in it. I do not see it as anything other than a penalty on the elderly and poor people of the country.

Chairman Humphrey. This will assess a greater burden on the old people at a period in their life when, for most of them, their income-earning ability is reduced or impaired?

Mr. Wilson. Senator, that is correct, because there are well-documented studies during the last 20 years that coinsurance among people who have money does not change their utilization patterns. It does among people who do not have any money. It is a redistribution of cost. And if you want to control your budget or if you want to cut down the premium for the insurance company by putting your deductibles in coinsurance, you can do that. But I think the documentation is rather overwhelming against changing patterns except for poor people.

Chairman Humphrey. Of course, Medicare is essentially a hospital program and for a medicare patient to receive, for example, medication as a part of the medicare itself, he has to go to the hospital. You do not really have outpatient care for most Medicare clients, particularly with prescription drugs. Is that not a fact?

Mr. Wilson. There are many inadequacies in the way that is approached and it does have incentives to use the hospital. It particularly has incentives to use the extended care facilities and I think there is increasing question as to whether this is a medical service. An important social service, I would agree. But I think there is increasing question about calling this a medical service. The incentives are all in those directions.

Chairman Humphrey. You have listened to the testimony this morning of Dr. Edwards. Would you care to make any comment on any

part of that testimony or my cross-examination? I would welcome your view. You noted my keen interest in the funding of medical colleges or schools, even though I recognize that they may not always be administered under the soundest business practices. But I would welcome any commentary that you or Dr. Mayer may have, either one of you.

Mr. Wilson. Let my colleague start and I will pick up, perhaps.

Dr. Mayer. Mr. Chairman, I think that one of the issues that strikes me pretty hard relates to one statement in Dr. Edwards' testimony where he calls for reducing training grants in order to correct "the inequity" with regard to the types of students and types of manpower that we have been training. I would question if this is appropriate. It appears to me to be an approach to the problem with a meat cleaver, as opposed to looking at it from the perspective of perhaps the problem being not so much cutting where we have been with training grants but rather adding to that something which we do not have. If the issue is to supplement where we have been with our basic research support by adding programs that now direct their attention to health care delivery or primary care, I wonder if it really makes sense to cut out something which we have already begun in basic research in order to build new approaches. Indeed the policies of this country should recognize that it is clearly desirable and probably possible to support both approaches.

It seems to me as if the administration is not considering that.

Chairman Humphrey. What, Dr. Mayer, would you consider the Government could do to hold down the rise in medical costs—not just the whole spectrum of health care costs?

Dr. Mayer. I would like to hark back to the conclusion of our statement. I am not sure that the Government is going to get very far if its approach is only to consider medical costs in vacuo. We think the health care system, and it is a system, is incredibly complex. It has components of manpower production, manpower distribution, facilities construction, service utilization, financing, and organizational patterns. The cost of medical care would be in that. I would submit that the Federal Government is not going to affect significantly the cost of medical care until it begins to look at each of these pieces as they relate one unto the other. I personally feel that the oft-used cliche of yet another patch on the patchwork is quite appropriate.

In fact, if I could speak in analogy for a moment, I think of the apple as a very tasty fruit. If one takes a knife and cuts it into a series of small pieces, he in effect has what we have in the health care system, lots of pieces. Each perhaps tastes reasonably good and even tastes like an apple, but it does not look like one. The approach to improving the health care system is, in effect, like rebuilding the apple and putting the pieces together. However, what I see happening in this country is that people are in effect cutting the pieces into smaller parts while hoping to rebuild the whole. I would suggest, Mr. Chairman, that you use the resources that are available to you to see what you can do in giving this a comprehensive look and assuring those of us on the firing line that there will be, first of all, clear policy, and secondly, continuity with regard to that policy so that we begin to regain the trust and confidence in Government which I am afraid we have begun to lose.

Chairman Humphrey. Have you seen anything, Mr. Wilson, in the current planning of the Government—item one, in its budget for fiscal

1974, or in any of the memoranda or any of the commentary by the Department of Health, Education, and Welfare, that indicates that there is to be substantial restructuring of the health delivery system?

Mr. WILSON. No, sir. This is what troubles us. In Dr. Edwards' prepared statement, he says:

> First priority should be placed on reducing financial barriers that limit access to the needed health care. This is primarily accomplished now through the Medicare and Medicaid programs; it will be furthered by enactment of a sound national health insurance program on which we will soon be making our recommendations to the Congress.

Then we talk about deductibles and coinsurance for medicare people.

Chairman HUMPHREY. Yes.

Mr. WILSON. I am a little confused by that.

Chairman HUMPHREY. I was going to ask him about that, because we have added an extra $1 billion of cost to the medicare people by the cost-sharing provisions of coinsurance and the fees they have to pay.

Mr. WILSON. I can only echo what Dr. Mayer has just said. Until someone—and I spent some time in Canada and they are a lot closer to it than we are—looks at the needs of people both in terms of the number of personnel required and the distribution of those personnel and stimulates the universities or the appropriate educational instiutions to train those people, we will make little progress. Further, this must be done over time, not starting one day and stopping the next. Finally, this must be looked at in its totality and through the development of a national health policy; not national health insurance, but a policy, that will look at all these factors. The evidence is really overwhelming that if you tinker with one bit and piece, you inevitably get bad results. For example, community mental health service budget line by line looks pretty good. But to have dumped the community mental health centers in the States without regard to the State mental hospital system as we have done is a self-fulfilling prophesy. You could tell they were going to be doomed. Nobody looked at the total picture.

When I was in Cleveland, the UAW decided they needed psychiatric benefits. There are 150,000 people related to the auto industry in the Cleveland area. They put in a huge sum of money, something like $1 billion a year being the potential, but they never used it. At the time they announced that psychiatric program, we were having difficulty getting suicidal patients to a psychiatrist.

Now, what is the purpose of promising people all these psychiatric benefits when we know there are not the psychiatrists to provide the services?

We deal with beds one day and mental health the next as if people were bits and parts, at the very time they are asking for total service.

I see nothing in the proposal before you here as legislation or certainly in the administration that will lead me to believe that anybody has looked at the whole picture.

Chairman HUMPHREY. This is what has bothered me over the years. I have looked at comprehensive health insurance, and I have talked to groups that have come to me in Washington. The last group said something along the lines of what you are saying; namely, that before we talk about how we are going to finance it, we had better have some idea of how it is going to operate. What is the structural formation, what is the interrelationship between the many facets and parts of the total

medical care system or the health care system? And really, most of us are so concerned about this project that we return pell-mell with our pet project.

For example, so many of us have a hospital, then we get concerned that we are going to work on cardiac treatment, cardiac centers. Then it is another one on kidney transplants and so on, rather than the total look or the broad look at the total picture. It is men like yourself and Dr. Mayer here who can really help us in outlining the component parts that need to be examined and what their relationship needs to be in order to design a health delivery system.

I have never seen, for example, an advisory council or a commission or whatever term you wish to put to it that has had as its mission a directive to prepare for the Government of the United States and to prepare for the community—I mean the total American community—a design or a drawing or a picture or a description of a total, a fully integrated health delivery system, the kind of structure that is needed.

Now, maybe it is because I have not read enough and I am not too well informed on it. Could you help us with something like that?

Mr. Wilson. It would be my pleasure, Senator, because I think you are now at the heart of the issue. I am very uneasy about national health insurance, because I think it will produce more money—it is almost—may I speak off the record for a moment?

Chairman Humphrey. Yes.

[Discussion off the record.]

Mr. Wilson. The absence of a comprehensive approach to this is, in our judgment, the fundamental issue.

Dr. Mayer. Mr. Chairman, if I might say one more thing.

Chairman Humphrey. Yes, Dr. Mayer.

Dr. Mayer. You talked about multiple components, and I share Mr. Wilson's response to your question as far as the delight we would have in being of assistance. But I think there is one component which, at least based on some of our experience in North Carolina, you ought to know about. We do not quarrel with Dr. Edwards or anyone else who calls for increased efficiency. We agree with that and with increased coordination and the reduction of duplication.

One of the fundamental factors that is going to have to be built into the equation to allow us to get to these points, however, is indeed the willingness of institutions and communities to cooperate together. We are pleased to report to you today on an experience that we are having in our own State of North Carolina through a program which we call the area health education centers program. In our case, this program is funded substantially and generously through the Bureau of Health Manpower of the National Institutes of Health under the Comprehensive Health Manpower Training Act, as well as through local and State funds. What we are attempting to do is to build a network of what we call clinical centers of excellence in communities through a scheme which intimately relates community hospitals to the university for education and training of all forms of health manpower.

The reason I bring this up with you today is because our experience in this program, to my pleasure and to a certain degree a bit to my surprise, has been that the willingness and the interest at community levels in cooperating with a group such as the university, which brings State and Federal funds, supplementing local funds, is exemplary. We

have had extremely excellent cooperation from a series of five centers that we have now helped to develop. These centers in turn, are linking up with smaller community hospitals in their several county areas in a true partnership relationship.

Now, this is in the area of education and not so much in the area of services delivery. But at least in this area, there is tangible evidence in this Nation that people are willing to cooperate in working together. We will destroy this willingness with time if, indeed, this program and others which I am sure are developing elsewhere in the Nation, do not feel that there is a thread of continuity, a thread of time, a thread of continued resources to keep this going.

I wanted to share with you the component of willingness to coordinate and to reduce duplication through this actual operational example. What we and other institutional/community-grouping need now is, indeed, continued cooperation and support through a clear health policy because none of these things are developed in 1 year and none of them can prove their potential in less than 5 years or 10.

Chairman Humphrey. And again, we need the experimentation of these things that can come in areas such as you have spoken of in a State or in a region so you can test them out.

I am a proponent of a form of some kind of national health insurance. I go back again, it is a means of financing, but I repeat what sometimes has gotten me in trouble with certain constituents; namely, that until we are tooled up, to use a phrase, until we are prepared to do a job of delivery and provide a means of accessibility and really know what we mean by a heath care system, we will just be raising money and spending it. I am not adverse to that, because I have been accused many times of being one that was willing to spend more money than some people wanted to see spent. But I think that we are on the political issue here in the Congress on health insurance which is highly controversial—at the expense, may I say, of really facing up to the structural organization that is required.

One of the things that I hope I can do as a Senator in hearings like this and others is to focus attention on the very things that you gentlemen have brought to our attention here this morning—not merely the efficiency and the cost, but rather, how do we put the machine together?

I mean we have all the parts spread all over here and they are all chromium plated, in a sense. They really all look very good, and we can shine them up a little more and get a new model of this part and a new model of that part, but until we know how they function as a mechanism, as a totality, I do not think we are really going to be getting the most out of what we are providing.

Mr. Wilson. Senator, there are two parts to that, and just at least one comment on my part. The American people and the Congress seem to be hung up on how much Senator X or Representative X's bill will cost, whether it is $70 billion or $100 billion or whatever and what the services are. If one looks at the rest of the world, the English are just now after 25 years trying to unscramble the organizational mess that they made in 1947. We would urge that this Congress not do that and so the structural organization problem, we think, is terribly important before we plunge into it, because when one looks around the world, you tend to freeze all the bad habits into place with national financing.

Chairman Humphrey. Very good. Now, Mr. Wilson, Dr. Mayer, if

you would do me the great favor of putting down in a little more detailed terms some of your suggestions as to structural organization, some of the things we have been talking about here, it would be very helpful, because I am an articulator for this sort of thing. What is more, I would like to have this record show that kind of more sophisticated or constructive approach to the whole subject of health care and its relationship to the consumer.

Mr. WILSON. We will be happy to do that, sir. I must say that in the time it would take to do that properly, it will be somewhat limited, because it would take some months for us to do an adequate job to prepare what you would like.

Chairman HUMPHREY. I am a patient man. Whatever you can do in the short term, we will appreciate; in the long term, we will be everlastingly greatful.

Mr. WILSON. I will be happy to, Senator.

Chairman HUMPHREY. Thank you very, very much.

We are adjourned, subject to the call of the Chair.

[Whereupon, at 1 p.m., the subcommittee adjourned, subject to the call of the Chair.]

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